

**Care amidst the condos?  
Understanding gentrification's unjust impact on social and health service delivery to  
vulnerable populations in Ottawa, ON**

by

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## **Abstract**

For cities' most vulnerable populations, community-based social services have long served a critical need, offering diverse health and social programs geared towards those who have traditionally faced barriers accessing care. With services historically and still largely located in inner city neighbourhoods in Canada (and in close proximity to areas where their primary clientele resides), community health centres (CHCs) have long operated on mission statements centered on the equitable distribution of services, the mitigation of social disparities and the provision of programs that embody an ethics of care. As capitalist decision-making structures, neoliberal discourses and distributive injustices converge through processes of rapid gentrification, however, CHC clients already experiencing institutional oppressions are now subject to the proliferation of further health and social inequities. This is a result of significant changes to the surrounding social and built environment, which is rendering critical programs, services and former spaces of care inaccessible and exclusive. Using qualitative data gathered through interviews with social service workers embedded in CHCs in downtown Ottawa neighbourhoods, this thesis critically explores how gentrification and new constraints on social service delivery interact, to unjustly impact the overall health of vulnerable populations.

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**Preface:**  
**Centretown as a microcosm for socio-spatial injustice**

In the summer of 2012, many residents of Ottawa, Ontario's Centretown neighbourhood (this researcher included) found themselves scratching their heads in confusion when bus shelter advertisements and large canvas signs draped over the sides of buildings began appearing, labeling the area as "South Central Ottawa", and proclaiming that it was "the next great hood". At the time, the construction of a major condominium project in the downtown neighbourhood was well underway, which planned to bring 540 new residential units (with price tags of about \$480 CAD per square foot) to two city blocks at the corner of Bank Street and Gladstone Avenue; an area previously occupied by a church and a surface parking lot. The sleek, glass buildings represented a visible departure from Centretown's traditional landscape of heritage homes, low- to mid-rise apartments, storefront walk-ups and rooming/cooperative housing. It was more than these physical changes to the neighbourhood, however, that indicated oncoming, oppressive processes of gentrification. It was the re-branding efforts of Toronto-based developers Urban Capital Property Group that symbolized the shift in power between the populations who relied on Centretown's diverse socio-spatial landscape and those who could afford to re-build and homogenize it. Though the "Central" condominiums were being built in Centretown, the developers' marketing efforts indicated that these new dwellings were not meant for the neighbourhood's incumbent residents, but for the wealthy newcomers.

Bounded by the Ottawa River to the north, Highway 417 to the south, the Rideau Canal to the east, and Bronson Avenue to the west (ONS, 2016), the traditionally mixed-use neighbourhood of Centretown is one of Ottawa's oldest and most diverse downtown communities. It is made up of bars and restaurants, retail shops, government offices, heritage buildings, embassies and residential properties. The neighbourhood's sizable concentration of social services, paired with its large number of lower-income housing options, public parks, and major transit service lines, has long made it a place where some of the city's most vulnerable populations can participate in social life and community networks and access critical health and social programs that address their unique and intersecting needs. Compared, for instance, to the Ottawa average of seven kilometres, the average distance to a community health and resource centre for Centretown residents is 0.8 km; proximity to mental health services is 0.9 km, compared to the average 9.6

km; and the number of “social and affordable” housing units in Centretown in 2009 was 2,624, compared to the Ottawa neighbourhood average of just 229.4 (ONS, 2016).

Centretown remained largely untouched by redevelopment projects from 1970 to 2000, thanks to the introduction of the Centretown Plan in mid 1970s. This community design plan, developed by the City of Ottawa and the Centretown Citizens Community Association, discouraged building demolition and high-rise development in order to preserve the neighbourhood’s character while allowing a moderate increase in population. The 21<sup>st</sup> century, however, brought about major changes to the core part of Centretown’s landscape, as residential growth stimulated new condominium developments (City of Ottawa, 2013, p.24; CCOH, 2016). From 2000 to 2013 in fact, more than 17 new condo projects were realized in the neighbourhood, resulting in more than 2,000 new units. As of 2011, another dozen Centretown condominiums had either been approved for construction, or were in their planning stages (City of Ottawa, 2013).

While groups like Urban Capital often position redevelopment projects as positive examples of municipal “intensification” policies at work, the unjust impact of the economic, physical and social “upgrading” of a neighbourhood for vulnerable populations is largely left out of the neoliberal discourses that have come to guide urban planning policies (Marcuse, 2015). Urban intensification can have negative impacts for those who can no longer afford to participate in their neighbourhood’s socio-economic landscapes (Webb & Webber, 2017; Betancur, 2011; DeVerteuil, 2011; Hackworth, 2007; Mazer & Rankin, 2011; Newman & Wyly, 2006). Rapid gentrification of an area functions not only to displace lower-income people as a result of pressures on affordable housing and rental costs, but can also result in a sort of “dispossession” of the neighbourhood, where spatial transformation can mean disproportionate social limitations for neighbourhood residents (i.e. disenfranchisement from public space or loss of community networks) who are poor, homeless, elderly, racialized, of a sexual minority group, or are living with addiction(s), disabilities and/or mental illness (Marcuse, 1985). For those already marginalized, processes of gentrification have the potential to create even greater injustices.

Ultimately, Urban Capital decided to quietly conclude its “South Central Ottawa” marketing campaign following public protests from Centretown residents and businesses that opposed the neighbourhood rebranding (Abdellatif, 2012). However, the ultimate construction of the “Central” condominiums – and the subsequent condominium projects that have sprung up in the area since –

have succeeded in forever changing the lives of residents in the community, even though the original neighbourhood name still remains.



*The completed, three-phase “Central” condominium project at Bank Street and Gladstone Avenue aptly depicts Centretown’s ongoing socio-spatial transition. Due to its heritage status, the fading brick facade of the former Metropolitan Bible Church remains, providing a stark contrast to the new glass condos towering over it. (MJ Deschamps, November 2015)*

While ongoing residential and business redevelopment projects such as Urban Capital’s “Central” condominiums aim to make the downtown core more “liveable” for a small, privileged group, these processes of gentrification simultaneously subject the city’s poorest and most vulnerable populations to a vicious circle of increased marginalization, economic polarization and social injustice (Brown-Saracino, 2017; Hackworth, 2007; Marcuse, 1985). At the same time, the numerous social services concentrated within Centretown and other downtown Ottawa neighbourhoods, which have long helped to mitigate some health and social disparities for vulnerable populations, are becoming increasingly inaccessible. Analyzing and understanding the impact that gentrification is having on the overall health of vulnerable populations in the context of community-based social service delivery is the basis of this study.

This thesis is organized into five chapters. Chapter 1 includes an introduction and brief contextualization of Ottawa’s neoliberal discourses, its climate of community-based care, and its recent history of urban redevelopment. This chapter also establishes the study’s research question and objective, discusses data collection methods, and explains why approaching this research from a social justice perspective is important to the goal of identifying and providing health and welfare services for groups of vulnerable populations. Using theories of intersectional feminism and others favoured by social justice scholars as a conceptual lens, Chapters 2, 3 and 4 blend together the

findings of five qualitative research interviews with frontline staff at three different urban community health centres and a comprehensive literature review to analyze three overarching themes. These chapters analyze how neoliberalism and neoconservatism, gentrification, and the marginalization of social service delivery work together (and apart) to produce social and health injustices for vulnerable populations within urban Ottawa neighbourhoods.

Chapter 2 discusses how social and health inequalities are systemically being produced and reproduced for vulnerable populations through neoliberal and neoconservative-based economic, political and social policies, and how municipal, provincial and federal economic reforms have led to oppression and distributive injustices within the context of social service delivery in downtown Ottawa neighbourhoods.

Chapter 3 analyzes some of the socio-spatial impacts of processes of rapid gentrification on vulnerable populations, including displacement, economic polarization of the population, community disintegration, and the privatization of public spaces. This chapter also discusses some of the particular challenges and socio-spatial barriers that both social service workers and clients in urban Ottawa neighbourhoods are experiencing as a result of neighbourhood gentrification, and how these challenges are contributing to the production of health inequalities.

Using some of the main themes from Chapters 2 and 3 to frame its argument, Chapter 4 argues how intersecting axes of socio-economic oppression are working together to produce new health inequalities within neighbourhoods through the context of CHCs and their respective programs and services. Largely based on narratives from frontline social service workers who express ways in which they are experiencing marginalization themselves, this chapter explores what happens to community-based service delivery and the ultimate health outcomes of a neighbourhood's most vulnerable clients when increasingly neoliberal practices occurring *inside* CHCs intertwine with processes of gentrification occurring *outside* CHCs.

Chapter 5 summarizes the major themes from this study, and concludes that increased oppression and inequitable health outcomes are being systemically produced within urban Ottawa neighbourhoods, at the interaction of neoliberalism, gentrification and community-based care.

## **Chapter 1:**

### **Introduction: Community-based care in changing urban Ottawa**

To be able to live healthy and stable lives, vulnerable individuals require tools and resources that allow them to prosper within sustainable communities and neighbourhoods, where they may experience reduced oppression or economic polarization (Marcuse, 1985). Since their creation in the 1960s, community health centres (CHCs) have long fulfilled this critical need, offering health services and wellness programs to vulnerable populations within their respective geographical catchment areas. In the context of this study, “vulnerable populations” can be defined as any individuals who may have traditionally faced institutionalized oppression or barriers accessing care. Though the CHC clients referred to in this study inevitably experience numerous and intersecting oppressions, the reasoning behind the umbrella grouping was to try to avoid ranking of oppression, and to understand a diversity of ways in which individuals and groups are being marginalized as a result of urban change in Ottawa neighbourhoods. “Vulnerable” individuals who access CHC services may include those who do not have regular healthcare providers; newcomers to Canada; and those who wish to access equitable services while facing obstacles such as language, disability, homelessness, addiction and/or mental health issues (MOHLTC, n.d.). Funded largely by the Ontario Ministry of Health, the province’s 74 CHCs serve approximately 500,000 people, with half of them accessing primary health care services (in addition to – or in isolation of – social and cultural programs). These non-profit health care organizations are unique compared to other health models, as they provide not only primary and preventative health care, but also play an important role in individual and group empowerment, through their offerings of culturally-adapted programs and drop-in services tailored to neighbourhood-specific needs (AOHC, n.d.). At its core, healthcare provision, through the perspective of CHCs is not seen as purely medical, but as inclusive of “practical or emotional support” (Milligan & Wiles, 2010, p. 737).

With services historically and largely located in mixed-use, inner city neighbourhoods, in close proximity to areas in which their primary clientele resides, CHCs have long operated on mission statements centered around the accessible, single-point distribution of health services and the mitigation of social disparities. However, as significant residential and commercial redevelopment projects continue to alter the physical and symbolic landscape of downtown Ottawa, a notable demographic shift is also taking place as urban living becomes increasingly attractive to the city’s

more privileged populations. This rapid process of socio-spatial transformation has made it critical to understand how CHC service delivery, accessibility and the overall spaces of care that CHCs provide are being impacted for those who rely on community-based services.

As historically mixed-use, inner-city neighbourhoods like Centretown become increasingly gentrified, poor and disenfranchised residents are now facing displacement pressure due to rising rental costs, disintegrating communities, and the creation of spaces of exclusion by those with financial power (Kern, 2016; Hackworth, 2007; Marcuse, 1985). Being displaced from the inner city into cheaper, less central neighbourhoods can cause a ripple effect, wherein vulnerable populations may find themselves subject to increased marginalization due to cuts in community ties, decreased mobility options and difficulty accessing critical health and social services within a supportive context (Twigge-Molecey, 2014; Betancur, 2011; DeVerteuil, 2011; Mazer & Rankin, 2011; Newman & Wyly, 2006).

As gentrification is posing increased socio-spatial challenges for vulnerable populations within their respective communities, post-1980s neoliberal policies are also lending themselves to the creation of systemic barriers as municipal governments have drastically shifted their levels of intervention around the delivery of health and social programs (Gattinger & Saint-Pierre, 2010). In recent years, the City of Ottawa has made deep cuts to welfare coffers, which previously helped fund many of the city's community-based programs. In 2015, for instance, the City of Ottawa's annual budget included a major scale back in funding for several inner-city drop-in programs, which had long offered critical health and welfare services. That year, Centre 507, a Centretown-based adult drop-in and support service, lost \$350,000 in funding (just over half of its annual budget of \$650,000), forcing the centre to dramatically reduce its community drop-in hours and outreach programs for homeless and precariously housed clients (Pearson, 2015b). The Odawa Native Friendship Centre, a non-profit organization that provides services to Ottawa's Aboriginal community was also forced to close its Lowertown drop-in centre for homeless clients in 2015, while downtown women's drop-in centre The Well, and women's housing organization Cornerstone, lost significant funding at the end of the city's fiscal year (Pearson, 2015b). With resources for community-based outreach and drop-in programs being cut, and affordable housing being replaced by condominium projects, the systemic oppression of vulnerable populations in Ottawa continues to be exacerbated by an increasing number of socio-spatial barriers to health equity.

Beyond distributive injustice, lack of recognition of the diverse needs of Ottawa's vulnerable populations leads to institutionalized arrangements or social policies that do not view economic and cultural/social needs in conjunction (Fraser, 1996). Though Ottawa's municipal government is responding to the city's housing crisis through its ten-year, CAD\$14 million "Housing and Homelessness Investment Plan", the Housing First strategy it employs has been criticized as failing to account for the diverse needs of those systemically oppressed, who require more complex solutions than roofs over their heads. The premise of Housing First, an internationally-adopted government approach that focuses on finding permanent housing for the chronically and episodically homeless as an alternative to emergency shelters/transitional housing, is that chronically homeless or precariously housed people have the right to stable housing. Critics argue, however, that the Housing First strategy neglects the benefits that individuals can reap "from living in supportive, congregate or group settings" (Klodawsky, 2009, p. 592). For example, Ottawa's Housing First plan fails to address the issue of spatial justice alongside that of housing and social justice: It gives no indication as to where affordable housing will be located, or whether those vulnerable populations moving in would be able to physically access the health and welfare services they need to overcome social, cultural and spatial inequalities (Hankivsky et al., 2011). According to Klodawsky et al. (2006), the grouping of diverse identities with differing needs under umbrella policies like Ottawa's "Housing and Homelessness Investment" plan "neglects...complex gendered and racialised bodies" (p. 432) through power dynamics that systemically produce inequalities.

While distribution and re-distribution of services is certainly an important goal in alleviating oppression, achieving justice for vulnerable populations requires a critical look at how political, economic and structural contexts "create ongoing conditions of inequality" in the first place (Hankivsky et al., 2011, p. 12). According to Hankivsky et al. (2011), achieving justice within the context of health is about "addressing the historical roots and structural conditions that give rise to the specific social problems confronting those most oppressed" (p. 12). Using a social justice-oriented, intersectional feminist framework, this thesis will identify the new differentials in resources that exist at the intersection of gentrification, neoliberal discourses and distributive injustices, and will also confront the hierarchal systems and axes of inequalities that have created these differentials.

## **Research questions and objective**

Though research does exist around the direct (and indirect) impact of gentrification- induced displacement for vulnerable populations (Boudreau et al., 2009; Hartman, 1984; Davidson and Lees, 2004; Lees et al., 2008; Linton et al., 2013; Marcuse, 1985; Martin, 2007), the current literature lacks a detailed, social justice-oriented analysis of how significant socio-spatial changes within cities are producing inequalities in the context of social service delivery and accessibility.

According to a World Health Organization (WHO) report on health equity and social determinants of health (2008), in order for citizens to experience health equity, they must live in healthy places that ensure access to the goods and services that will allow them to thrive. For the first time ever in 2007, the majority of world's population was living in urban settings – however, the necessary political structures, financial resources and social policies that would create conditions for people to thrive in these new settings continue to be significantly lacking. The rise in urban sprawl in the 21<sup>st</sup> century has called for a significant need to examine the uneven geographic distribution of health services and outcomes as a way to achieve health equity, especially in light of the fact that approximately 80 percent of Canada's population now lives in urban areas (Williams & Kitchen, 2012). While the impact of urbanization on a region or city as a whole is increasingly been discussed in academic literature, there is little known about how different interactions at a neighbourhood level, within different localities, collectively influence health outcomes (Macintyre et al., 2002; Williams & Kitchen, 2012; Shah et al. 2016).

Beyond the biomedical classification of health, which merely looks at the presence (or absence) of disease in a physical sense, “a broader definition embraces the idea of health as a state of physical, mental, social and spiritual well-being, not merely the absence of disease or infirmity” (Murphy et al., 2008, p. 70). According to Murphy et al. (2008), neighbourhood gentrification functions to impact two key community health values: Health protection (the need to enable community services and leaders to become resilient to physical/social transformation) and health equity (the need to ensure fair distribution of health services and resources within the population). For those low-income, marginalized populations living in gentrifying neighbourhoods, the growing health inequities they may be experiencing can be associated with many interacting factors, including displacement, lack of proximity to services, the rising cost of living, and the real or threatened loss of health care services.



Living conditions associated with varying levels of social and economic development are more significant in determining whether people become ill [than medicine]. The impact of non-medical services and resources indirectly influence the determinants of health. These include...services providing access to education, housing, employment, [etc.]” (Murphy et al., 2008, p.71).

An analysis of the interaction between space and health is key in efforts to ensure equitable outcomes for vulnerable populations, as central to the idea of social justice “is the role of space in producing and resisting domination and repression (Chung, 2013, p. 2459).” In the context of this research, the use of social justice-oriented theories involves a look beyond the proximal causes of ill health, and towards “optimal conditions whereby individuals have the capability to be healthy” (Carr, 2014, p.6). Rather than criticizing distributive injustices alone, this approach confronts the social structures and institutions that determine unjust distributive patterns across different neighbourhood spaces (Young, 1990). Through this lens, health disparities take on a different meaning, as they refer not only to how individuals fare, but what differences exist between socially dominant and socially disadvantaged groups (Carr, 2014). In the context of this study, an analysis of changing social and spatial conditions helps identify the impact of gentrification and differentials in social service delivery on the overall wellbeing of vulnerable individuals, and works to achieve one of the goals of social justice-oriented research, which is “to examine and understand systematic social inequities that privilege or marginalize particular groups of people (Fassinger & Morrow, 2013, p.75)”.

This study draws largely on narratives gathered through five semi-structured interviews with social service workers and health professionals employed at three different community health centres (CHCs) in gentrifying downtown Ottawa neighbourhoods. Through a critical analysis of these narratives, this thesis argues how ongoing urban redevelopment projects interact with an overarching neoliberal/neoconservative political economy to create new socio-spatial barriers, oppressive subjectivities, and health inequalities for the vulnerable populations who have traditionally accessed social services within the neighbourhoods under study. Emerging themes from the below research questions were located within three distinct – but intersecting – fields of inquiry: Neoliberalism/neoconservatism, urban redevelopment/gentrification, and marginalization of service delivery.

1. How is neighbourhood gentrification impacting community-based health and social service delivery to vulnerable populations in downtown Ottawa?
2. What changes or pressures are social service workers at community health centres (CHC) in Ottawa's downtown core currently experiencing in terms of service delivery to vulnerable populations, and how are they understanding and interpreting the impact of gentrification on service delivery?
3. In what ways are the socio-spatial barriers understood through gentrification further oppressing already marginalized populations and producing subsequent health inequalities?

Using an intersectional feminist lens which recognizes that the health and social needs of urban residents are multi-faceted, this study is guided by a conceptual framework that evaluates how “social, cultural, and spatial powers collude and intersect to produce states of health” (Hankivsky et al., 2011, p. 4). Through this framework, the goal of achieving health and social justice and eliminating structural oppressions for marginalized populations requires a critical look not only at the impact of gentrification and neoliberal discourses, but at overarching and intersecting axes of inequalities. Confronting *how* power dynamics within cities systemically marginalize vulnerable populations can help produce more equitable outcomes.

When social justice drives the research, it becomes possible to identify differentials in access and resources, what specific services are needed, what policy areas require institutional support and development, and how people are exercising their agency (Dhamoon & Hankivsky, 2011, p.31)

A social justice-oriented approach to research probes beyond the single identities and experiences of social service workers and vulnerable populations, and considers, instead, a range of differences. This approach has the potential to produce a more critical understanding of a situation or system of disadvantage. Investigating the effects and producers of systemic forms of inequity and oppression can lead to more empowering outcomes for marginalized groups by informing policies and/or health and social service planning in a more holistic way.

This study aims to put the voices of social service workers front and centre, in order to take a more participatory approach to identifying inequities in terms of access to care and health/wellbeing resources. Though this work was unable to include the voices of vulnerable populations directly (due to time and resource restrictions), the social service workers who participated in this study have a unique perspective and understanding of the needs of the vulnerable clients they work with on a daily basis. While the social service workers interviewed

do experience privilege in many ways (e.g. all interviewees were white and employed) and cannot understand first-hand the full spectrum of oppression that many of their clients face, their narratives are an important piece of the puzzle in understanding gentrification's overall impacts. Social service workers at CHCs in Ottawa are in a unique position, dealing directly with both vulnerable populations (whom government policies affect) and administrators/policy makers (who write and/or administer policies). Their perspectives on how gentrification is further marginalizing their clients, and how changing CHC and government policies are simultaneously marginalizing their own capacity to provide services, are uniquely valuable and limited within current literature. The end goal of this social justice-oriented research is to contribute a health inequity perspective to a body of knowledge that analyzes how neoliberal decision-making structures manifest through processes of gentrification to perpetuate and produce new, intersecting oppressions for vulnerable populations.

### **Data collection and methods**

To gain a particular understanding of how neighbourhood gentrification produces health inequities and injustices for vulnerable populations, semi-structured interviews were conducted with social service workers at community health centres (CHCs) in urban Ottawa neighbourhoods, using a critical ethnographic approach to research. Ethnographies focus on entire culture-sharing groups, and in this case, CHC staff that work directly with vulnerable populations in gentrifying Ottawa neighbourhoods served as the culture-sharing group. While a “realist” type of ethnography involves an objective account of a situation based on information learned from participants at a field site(s), a “critical” ethnography seeks to confront inequities in society and use the research as a tool to advocate for change (Miller & Salkind, 2002; Stinnett, 2012). A critical ethnography is a research methodology that “begins with a responsibility to address the processes of unfairness or injustice within a particular lived domain” (Oladele et al., 2012, p.8). Through the recording and analysis of the first-hand experiences of frontline social service workers, it became possible to uncover several systems and incidences of unfairness and injustice that may be directly impacting vulnerable CHC clients. The narrative-focused study that follows incorporates direct quotations from research participants wherever relevant, and organizes literature reviews and primary qualitative research in a thematic way, in order to tell a story that highlights the particularities of ongoing health injustices in gentrifying Ottawa neighbourhoods. The research objective here was

to examine a cultural system of power, prestige, privilege and authority (Creswell, 2013) as understood by frontline social service workers, to produce a body of work that can be used to influence and orient health policy and/or health system planning to better meet the intersectional needs of vulnerable populations. Bringing this type of culture-sharing group together through this research can help provide insights to both CHC management and health decision makers in regards to how processes of gentrification may be unjustly impacting service delivery and accessibility at different centres in both unique and similar ways. Though CHCs in Canada largely operate on similar mandates, little is currently known cross-culturally about the different challenges that social service workers in changing urban neighbourhoods face, and what strategies they may employ to mitigate oppression for their clients. By telling some of the “missing stories” of vulnerable clients through social service workers – who also reveal ways in which they, themselves, are becoming increasingly marginalized – this study arrives at multiple, multifaceted truths that reveal systemic injustices (Howard et al., 2016).

The bulk of research for this study was undertaken over a nine-month period, from June 2015 to February 2016, with participant recruitment based on purposive, variation sampling. The five participants in this study were selected based on the fact that they work on the frontlines with different groups of vulnerable populations to distribute services. The diversity of experiences and narratives shared by research participants is based on the fact that clients served come from different neighbourhoods (a different set of bodies facing similar and unique issues), and represent different vulnerable populations (e.g. homeless youth, illicit substance users). In order to qualify for this study, participants had to have worked directly with vulnerable clients for at least five years at their current CHC; either inside the centre (e.g. through drop-in programs and appointment-based services) or outside the centre (e.g. through outreach programs like mobile street services). The participants work directly with vulnerable populations through a multitude of specialized programs and services, including harm reduction programs, housing services, health and counselling services, and programs for specific cultural groups. Participants were also selected for the fact that they work in downtown Ottawa neighbourhoods that have been undergoing significant gentrification projects for at least five years. Exploring the same research questions with five frontline workers based in three different urban neighbourhoods in the same city aims to provide a more critical understanding of how service delivery interacts with particular geographical axes to produce inequalities. This approach to research embodies Wacquant’s (2012)

idea that there is no “big-N” form of neoliberalism – but instead, an indefinite number of “small-n” forms, which are “born of the ongoing hybridization of neoliberal practices and ideas with local conditions and forms” (p.70). Studying CHCs in different geographical locations within the same city was done to understand *place* not only as an axis intersecting with service delivery, but as an axis intersecting with different (and overlapping) marginalized identities as well, including youth; homeless and vulnerably housed individuals; illicit substance users; and Indigenous populations. In the context of an ethnographic approach to research, it was important to understand why CHCs in different geographical locations offered certain programs to certain groups in the first place, and what health inequalities might be produced for clients as a result of new socio-spatial barriers to those services. This method of variation sampling was also undertaken in order to produce a more diverse understanding of the health implications of gentrification on service delivery to vulnerable populations.

To recruit participants, program directors at several CHCs in downtown Ottawa were contacted (through either phone and/or email), and asked if they could forward along the letters of invitation provided to them (*see Appendix 1*) to staff at their centres that they believed fit the criteria of the study. It was stated clearly in both the conversations with program directors, and in the letters of invitation written for potential participants, that the *only* role of the program director would be to connect the researcher to staff members. The letter of invitation written for potential participants stated that they should contact the researcher directly if they wished to be interviewed for the study, so that their program director would not be aware of their decision (and, therefore, could not influence their choice to participate as a result of unequal power dynamics). Admittedly, this method of recruitment did have its potential limitations, as program directors were put in the position where they could act as gatekeepers if they did not want certain staff members to receive the letters of invitation. Ultimately, two participants were recruited this way, while the other three participants were recruited as a result of the initial participants passing along their respective letter of invitation to colleagues. This two-pronged process gave the researcher access to voices that were not initially made accessible during the first round of recruitment.

All interviews were conducted in person, in English, and were audiotaped with a digital recording device. Interviews ranged from approximately 1 hour to 2.5 hours in length. Participants were asked to choose the setting in which they would like to be interviewed, and conversations were ultimately conducted in individuals’ offices, CHC boardrooms, and coffee shops. Altogether,

a total of five individuals who work directly with marginalized populations to deliver critical social and health services in downtown Ottawa neighbourhoods were interviewed. All participants were given information-consent forms (*see Appendix B*) to sign prior to the commencement of each respective interview. On these forms, they were asked to indicate whether or not they consented to their first names being published in the final report, alongside any data used from interviews. Four out of five of those interviewed indicated that they wished to remain anonymous in the study's publication, and were thus assigned pseudonyms (*Erica, Steve, Jennifer, Chris*). One participant, Rob, consented to the publication of his real first name in the study. It was indicated in the information-consent form that even if participants wished to remain anonymous, the reporting of data might still run into limitations in terms of confidentiality. Ethics approval for this study was obtained through Brock University's Research Ethics Board.

A semi-structured approach to interviewing was employed during data collection, which allowed for all participants to share their unique perspectives on similar topics and areas of inquiry, while the researcher simultaneously had the flexibility to further explore any emerging themes. In several instances, the researcher's own observations and perspectives were brought into the discussion, in order to come to a more inter-subjective truth (White & Strohm, 2014; Madden, 2010; Cook & Crang, 1995), something that is important within the practice of an ethnography. Bringing the researcher's own perceptions and particular understanding of neighbourhood change and neoliberal policy-making in Ottawa into the interview process was important in order to avoid (as much as possible) some of the common critiques of ethnographies in terms of positioning research subjects as the "Other" (Fisher, 2014). Writing "with" rather than writing "about" the research participants was the aim of the researcher's accounts, and through each stage of data collection and analysis, the researcher critically re-evaluated how both her and her participants were being "inserted in grids of power relations" and how that positionality influenced "methods, interpretations, and knowledge production" (Sultana, 2007, p. 376).

Approximately one month following each of the interviews, verbatim transcripts were returned to the respective participants for review and comments, to ensure an equitable, reciprocal research gathering process, where participants could feel as though their own personal truths were ultimately communicated within the final transcripts. Analysis of the participant interview transcripts and field notes began by reviewing and open coding, which allowed the researcher to identify themes and commonalities in narratives in a systemic way. Emerging codes were then

grouped under three major, overarching themes: Neoliberalism/neoconservatism, urban redevelopment/gentrification and marginalization of service delivery.

Through each step of the research, data collection and analysis processes, reflexivity and positionality were things that I, as social justice researcher, was quite conscious about. A major reason why I chose to make CHCs in downtown Ottawa neighbourhoods the sites of study in this work is because I am from the city. I have either lived in, worked in, and/or frequented all of the neighbourhoods under study, and have a particular perception of how these areas have changed in terms of urban redevelopment (both residential and business) since the early 2000s. I also have a particular perspective of what the impact of socio-spatial changes have meant for residents. Having called the nation's capital home for almost three decades, I am privy to some of the less blatant, longer-term examples of oppressive neighbourhood changes that have taken place in downtown Ottawa, that I, myself, perceive as resulting from processes of gentrification and neoliberal discourses. I have seen and heard stories about a local park in Centretown, for instance (once a mixed-use space shared equally by office workers on their lunch breaks and low-income populations or drug users looking for a meeting spot), becoming a space of increasing contestation and policing by more privileged neighbourhood residents and law enforcement agents. I have observed Laundromats, corner grocers and greasy spoon diners disappear, and health food stores and expensive brunch spots take their places. I have noticed that I can no longer walk a few feet down most downtown city blocks without encountering construction sites with wraparound signs advertising "European-style" or "New York style" condos under development. Overall, I have seen for myself how the formerly mixed-use landscapes of some of Ottawa's most central neighbourhoods have become increasingly exclusive, ushering in a new kind of population while simultaneously creating spaces of marginalization for incumbent or former residents.



*Images taken in and around Ottawa's Centretown neighbourhood depict how ongoing redevelopment projects are rapidly transforming the built environment for a more privileged type of urban resident. See Appendix D for more photographic examples of neighbourhood transformation.  
(MJ Deschamps, November 2015)*

In addition to continually reflecting on my subjectivities as an Ottawa “insider” during the critical analysis and write-up of these findings, I also remained conscious of how my own experiences and privileges as a white, cisgendered, able-bodied, university educated, Canadian woman had the capability to shape my findings, interpretations and conclusions. This means that while I bring particular insider knowledge to the research, I also remain an outsider when it comes to experiencing certain intersectional oppressions. I have experienced the impact of rising transit costs, increased difficulty finding affordable housing in formerly affordable urban neighbourhoods, and decreased walkability to particular services and resources – however, I have a full-time job and certain financial means that allow me to adapt economically (for now). Through qualitative data analysis, I consistently revisited conclusions drawn, asking myself whether interpretations had been made from an overwhelming place of privilege, or whether I had managed to reach an inter-subjective truth (White & Strohm, 2014; Madden, 2010; Cook & Crang, 1995), by melding my own experiences with those of my participants.

Though it is sometimes argued that bringing a particular bias to a study can taint the outcome, the subjectivity that the researcher brings to this study is to the overall advantage of the research and cannot be avoided. Subjectivity and bias may be inherent in ethnographic research – or any research for that matter – but Cook and Crang (1995) argue that those two factors are, in fact,



what can give the study its reliability, and that researchers do not need to assume an abstract vantage point to conduct a study: “Ethnographers can not take a naïve stance that what they are told is the absolute ‘truth’” (p. 11). Instead, the researcher attempts to bring the research subject into the process to develop an inter-subjective truth, and better understand and make sense of the narratives produced in the context of larger social, cultural, political and economic conditions (Cook & Crang, 1995; Stinnett, 2012). Feminist social researchers Stanley and Wise (1993), who examine the “place of the personal within research” (p.150) also believe that the researcher’s self cannot be excluded or compartmentalized when conducting research. While researchers are often taught to mistrust experience over theory, Stanley and Wise (1993) argue that how researchers conduct and present research ultimately is not – and cannot be – pure or uncontaminated by the researcher’s subjectivity, as “all occurrences are a product of our consciousness because they derive from our interpretation and construction of them” (p.154). With that said, using critical ethnography as the research methodology in this study requires an understanding that research participants present certain representations of truth through their particular narratives and subjective understandings of the needs of vulnerable CHC clients. Though researcher and research participants both work towards the common goal of identifying inequalities and improving service delivery for vulnerable clients, the conclusions drawn in this study lie somewhere between the ideal and practice of critical ethnographic work. Here, the resulting “activity system” of a critical ethnography works towards “socially constructed goals [which] are distinct from the individual’s immediate interests, but which are recognized to serve those individual interests because the members of an activity system reach take part in establishing its collective goals” (Stinnett, 2012, p. 138).

With social justice and feminist intersectionality theories guiding the research and data collection, the researcher aimed to avoid, as much as possible, some of the common critiques of ethnographies such as positioning research subjects as the “Other” (Fisher, 2014), or unintentionally reinforcing “masculinist, colonialist representations” (p.2), by practicing reflexivity and considering her own personal and cultural context when collecting and interpreting the data. With the goal being to identify oppressions and inequalities experienced by vulnerable Ottawa residents living in gentrifying neighbourhoods, this researcher sought to identify a number of diverse truths by gathering a range of narratives related to health access and inequity, rather than analyzing certain programs and/or services geared towards particular, subscribed identities.

Through conversations with those engaged in service delivery, narratives around particular identities did, of course, emerge, but the overarching conclusions drawn reference the identities of vulnerable populations coalitionally, rather than individually. The motivation behind this was to try to avoid the “ranking” of oppression as much as possible.

## **Conceptual framework**

A conceptual framework of intersectional feminism guided each stage of research, data collection, and critical analysis undertaken throughout this study. Coined by Kimberlé Crenshaw in 1989, intersectionality focuses on “the vexed dynamics of difference and solidarities of sameness” (Cho et al., 2013, p.787). In the context of anti-discrimination and social movements, this perspective takes the view that women (and other marginalized bodies) experience oppression in varying ways and to varying degrees. Instead of drawing a direct line between a system of oppression and an oppressive outcome, intersectional feminism as a social justice-oriented theory understands that at any given time, patterns of oppressions are being produced by an individual’s location on social, cultural, political and economic axes. Using this framework, it is possible to conceptualize “the relation between systems of oppression which construct our multiple identities and our social locations in hierarchies of power and privilege” (Carastathis, 2014, p. 304). Since oppression is almost never clear-cut or static, a better understanding of how the marginalization of particular bodies is being produced in the first place can help CHCs better respond to the emerging health and social needs of their clients.

It is also important to analyze social and health oppression from a particular neighbourhood perspective, as the very idea of what it means to achieve social justice can vary greatly depending on the social, historical and geographical context (Webb & Webber, 2017; Davidson & Lees, 2004; Harvey, 1988; Mazer & Rankin, 2011). Social justice (or injustice) inherently has a strong spatial dimension, as human actions tend to occur and cluster around certain locations. In this sense, “human activities end up being unevenly distributed, thus producing either advantages or disadvantages – that is, spatial injustice – depending on where the activity happens and how accessible it is” (Ansaloni & Tedeschi, 2016, p.323). Beyond the geographic scale or passive dimension through which social justice occurs, Philippopoulos-Mihalopoulos (2010) views space as ontologically relational:

If spatial justice is simply just a distribution of resources in a given region, one is left wondering whether any justice can possibly afford not being “spatial” in this narrow sense. On the contrary, if the peculiar characteristics of space are to be taken into account, a concept of justice will have to be rethought on a much more fundamental level than that (Philippopoulos-Mihalopoulos, 2010, p. 189).

In this regard, geographical space is seen not just as a site through which social justice may or may not emerge, but as a dynamic and active player in the production of patterns of oppression. This perspective acknowledges that distributive justice alone cannot alleviate oppression, and that recognition of overarching and interacting systems and institutions of marginalization is also required (Fraser, 1996). While health resources, for instance, might be available within a particular neighbourhood, social or physical barriers could exist (both inside and outside CHCs) that hinder the ability of certain populations to access services. As Young (2004) argues, justice does not only have to do with distribution, but also “the institutional conditions necessary for the development and exercise of individual capacities and collective communication and cooperation” (p.3). In the most general sense, says Young (2004), “all oppressed people suffer some inhibition of their ability to develop and exercise their capacities and express their needs, thoughts, and feelings” (p.4). Within gentrifying neighbourhoods, these inhibitions or restrictions can become exacerbated as a result of the further privatization of public spaces.

Through the lens of intersectional feminism, categories of oppression – including spatial dimensions – are not distinct, but “always permeated by other categories, fluid and changing, always in the process of creating and being created by dynamics of power” (Cho et al., 2013, p. 795). This conceptual lens is especially beneficial for social justice-oriented research, as it brings to light not just a one-pronged, static outcome of a problem or inequality, but highlights its dynamics and lines of force by focusing on people and their experiences/interactions (MacKinnon, 2013) within particular socio-spatial environments. Rather than confronting systems such as racism, sexism and colonialism in and of themselves, this framework reveals, instead, what their intersection with other systems reveals about power (Dhamoon & Hankivsky, 2011). Current literature on intersectionality generally analyzes four different kinds of interactions:

The identities of an individual, set of individuals, or a social group that are marked as different (such as non-white woman, non-white women as a group, or a specific group of non-white women), the categories of difference (race, gender), the process of differentiation (racialization, gendering), and the systems of domination (racism, colonialism, sexism, and patriarchy) (Dhamoon & Hankivsky, 2011, p. 20).

Within this conceptual framework, an analysis of identity and categories are not erased, but “instead, the study of processes and systems requires an examination of how identities and/or categories are constituted, resisted and governed in the first place” (p. 24). In the context of this study, then, it is not possible to critique gentrification, alone, as the process or system of oppression leading to health inequalities without simultaneously confronting how interacting systems of “domination” affect individuals and groups within Ottawa neighbourhoods undergoing socio-spatial transformation (Dhamoon & Hankivsky, 2011).

Feminist theorists such as bell hooks and Patricia Collins have also emphasized the importance of studying cultural patterns of oppression in an intersectional, interrelated way – as the only way, in fact, to truly gain political and social equity. According to Collins (2000), “intersectional paradigms remind us that oppression cannot be reduced to one fundamental type, and that oppressions work together in producing injustice” (p.18). As understood through interviews with social service workers, the vulnerable populations who access CHC services within gentrifying neighbourhoods are perceived to be experiencing socio-spatial transformation and subsequent oppression differently. By analyzing oppression coalitionally across CHCs, rather than categorically, it is possible to identify differentials in care, and shape the argument that an individualized approach to the provision of services, programs and supportive infrastructure is required to achieve health and social equity (Carastathis, 2013).

Intersectionality also calls attention to the problematic formation of “top-down” public policy development, where “politics define identities, rather than identities defining politics” (Tomlinson, 2013, p.996), and aids in mapping the production and contingency of both subjects and identities (Carbado, 2013). In this context, frontline social service workers have a much better sense of the health and social needs of CHC clients than the administrators or policy makers who are responsible for the allocation of resources. Using this conceptual lens, the study argues that at any given time, a number of systems of oppression may be interacting within gentrifying neighbourhoods that may lead to inequitable service delivery for vulnerable clients.

From a social justice-oriented perspective, a multi-level intersectional approach to studying the complex and interrelated effects of gender, race, class and place on health outcomes has significant value for service providers. “Knowing an individual’s simple social location (such as female or poor) can provide insight about health outcomes, but understanding an individual’s

complex social location (female and poor) often provides additional information that helps to untangle the complex determinants of health outcomes” (Black and Veenstra, 2011, p. 87). In the context of this study, a feminist intersectional lens lends itself to a more holistic understanding of the marginalization of CHC clients, by highlighting how oppressive systems render certain bodies most susceptible to gentrification-induced displacement and disenfranchisement.

Before critically exploring how certain health and social inequalities are emerging within gentrifying Ottawa neighbourhoods, however, it is important to first contextualize and confront the city’s particular history of neoliberal policy-making and urbanization.

### **Ottawa 2001 – 2011: Amalgamation and urban transformation**

Prior to the condominium and urban redevelopment boom of the last decade or so, Ottawa’s previously most significant case of neoliberal urbanization began on August 23, 1999, when the Ontario provincial government gave the former Ottawa-Carleton Region 90 days to come up with a municipal “restructuring” solution that would “lower taxes, enhance services, reduce the number of local politicians, and increase accountability” (Rosenfeld & Reese, 2003). The solution ultimately decided upon by the region was to amalgamate 12 local governments into a new “megacity” and consolidated government entity, which would take over on January 1, 2001. The provincially appointed Transition Board was “given wide-ranging authority to supervise the activities and budgets of the existing municipalities, as well as to plan all aspects of the new City of Ottawa’s structure and operations” (Graham, Maslove & Phillips, 2001, p.262). By reducing the number of elected local officials (and thereby weakening the political power of local governments), this amalgamation symbolized a pivotal point in Ottawa’s increasing shift towards a more neoliberal, hierarchical structure of decision making, where the diverse needs and interests of local residents have become diluted and disconnected from governing and planning bodies.

Following the City of Ottawa’s macro-scale, political restructuring at the beginning of the 21<sup>st</sup> century, further micro-scale physical restructuring of urban Ottawa neighbourhoods soon began to take shape through an influx of residential and business investment aided by new urban redevelopment policies and initiatives. For the City of Ottawa, the 2001 regional amalgamation signalled the beginning of a period of rapid transformation for residents of the nation’s capital. With a population of 883,391 in the city proper (and just over 1 million in the wider Ottawa-Gatineau region) (Statistics Canada, 2011), the Ottawa urban area is now the fourth largest in

Canada, and growing rapidly: Between 2006 and 2011 alone, the population increased 8.8 percent; compared to the national average growth of 5.9 percent. It is estimated that by 2031, the city will support 30 percent more jobs; 30 percent more residents and 40 percent more households than in 2013 (City of Ottawa, 2013), with the majority of this growth taking place in highly concentrated, urban areas.

With a \$2.1 billion Light Rail Transit (LRT) line through the city's downtown slated to open in 2018; hundreds of millions of dollars in residential and business redevelopment projects underway in and near the Byward Market; and the majority of new infill homes being built in the city centre, Ottawa's core is currently undergoing some of the most rapid change that it has ever experienced. Though the municipal government positions this period of transformative growth as positive from an economic and social standpoint, Ottawa's ongoing redevelopment policies and projects are being largely tailored towards a very privileged group of citizens, only.

### **Present-day Ottawa: Swelling condo growth and a street-level housing crisis**

In what can be seen as both a cause and effect of the City of Ottawa's ongoing investments into urban redevelopment projects, the residential component of downtown neighbourhoods is now becoming increasingly exclusive. Overpopulated with a growing number of high-priced condominiums, many former mixed-use neighbourhoods are now being re-built for a more homogenous type of population.

In 2015, infill housing in Ottawa reached an all-time high, which the municipal government attributed to its "intensification policies continu[ing] to work" (City of Ottawa, 2015). That year, nearly 40 percent of new infill homes were built in key "intensification" areas as outlined by the municipal government, including the city's downtown core; near rapid transit stations; on prominent streets and in mixed-use areas (City of Ottawa, 2015). Of these new housing starts and completions, infill in the downtown core almost exclusively consisted of condominium projects (McIntyre & Wiebe, 2015).

Prior to 2001, Ottawa's condominium market was barely a blip on the radar. According to the Canada Mortgage and Housing Corporation (CMHC) (2002), the number of existing condominium units at the time was estimated to be no more than 17,250 – just under 5 percent of the city's entire housing stock. By the end of 2002, however, condo starts had grown to 747 units (compared to the 285 new units built in 2001), and average condo prices began to soar. According

to a report by the Canadian Urban Institute (2013), the dwelling growth in Ottawa's downtown between 2001-2011 saw a 61 percent increase. This influx can be largely accredited to the city's growing focus on downtown "revitalization" and investment, and the waiving of development charges that helped Ottawa see CAD\$235 million in residential growth over the same time period. In 2016, 1,793 residential units were issued building permits in Ottawa's "intensification" target areas (largely in the downtown core), amounting to almost 30 percent of the net new units issued permits in the city. Altogether, Ottawa's central neighbourhoods comprised 57 percent of the share of the city's total intensification from 2012-2016 (City of Ottawa, 2016).

Over the past decade, a number of plans and policies have been enacted as a part of this revitalization strategy, making it easier for developers to re-build the urban landscape for the most affluent. In 2007, the City of Ottawa adopted a Brownfields Redevelopment Community Improvement Plan, which offered financial incentives to private sector developers to redevelop land previously used for industrial or commercial purposes. Between 2007 and 2017, the City of Ottawa awarded CAD\$70 million in brownfields grants to developers (Chianello, 2017). In 2008, Ottawa City Council approved a comprehensive new zoning by-law, which harmonized the existing 36 zoning, by-laws from the city's former municipalities into one overarching by-law to facilitate the process for new developments. In 2009, a new residential land strategy to 2031 stated that "the City wishes to leverage the market's interest in urban living to rejuvenate, revitalize and repopulate certain older areas of the city" (City of Ottawa, 2009, p.26), effectively making urban redevelopment a visible political priority. By prioritizing capital accumulation rather than social diversity, Ottawa's current redevelopment plans fail to consider the various needs of the city's urban residents.

While the interacting, oppressive outcomes of "small-n" (Wacquant, 2012) neoliberal redevelopment policies such as these manifest themselves in some unique ways in Ottawa, the increasing separation of cities into wealthy and disadvantaged neighbourhoods – and the disappearance of the middle-class as a result of "intensification" projects – is part of a larger, long-term trend in metropolitan areas across Canada (Breau et al., 2017; Hulchanski, 2011). Hulchanski's (2011) study on income polarization and gentrification in the City of Toronto from 1970-2005, for example, tracks the systematic movement of poverty from the centre to the edges of the city. This trend, which saw more affluent households moving into the city centre while low-income households were pushed to the inner suburbs (with poor access to transit and social

services), now appears to be mirroring itself in Ottawa. Several social service workers interviewed for this study, for instance, discussed that they have noticed a growing number of their respective clientele being displaced to more suburban areas, due to a lack of affordable housing in the city centre. Although the ongoing segregation of the city by income is something occurring on a pan-Canadian scale, Hulchanski (2011) says that the impact of this trend is not irreversible or inevitable: “These trends could be slowed or reversed by public policies that would make housing more affordable to low-income households, by efforts to expand access to transit and services in neighbourhoods where the need is greatest” (p. 5).

The City of Ottawa is currently carrying out its ‘10 Year Housing and Homelessness Plan’ to increase access to affordable housing for those who are homeless or at risk of homelessness. However, the municipal government’s simultaneous focus on “intensification” and high-end condominium/business redevelopment in the downtown core (where the majority of the city’s social/health services and accessible transit options are located) is working to exacerbate the city’s affordable housing issue through increasing rental costs, displacement of residents, and disappearing community-based resources and supportive infrastructure. Despite the municipal government’s \$259 million investment in the renovation and rehabilitation of social housing units in 2015 (City of Ottawa, 2015), the Alliance to End Homelessness Ottawa (2015) reported that in the same year, more individuals were using shelters (a 4.9% increase compared to 2014); more families were homeless (a 10.8% increase compared to 2014); and the *least* number of new affordable units since 2005 had opened (only 34 new affordable housing units opened in 2015 – the lowest number in a decade). Ottawa’s aging demographic was also reflected in the homeless population in 2015, with an increase in the number of older adults (aged 50+) accessing shelters. One year later, in 2016, the number of single men and women and older adults accessing shelters continued to increase, along with the trend of families accessing shelters (a 12.5% increase from 2015). With Ottawa’s family shelters currently full, the City of Ottawa spent \$4.5 million in 2016 to house families in off-site motels, rather than invest in long-term housing solutions (Alliance to End Homelessness Ottawa, 2016).

Meanwhile, although the GDP in Ottawa has grown very little in recent years (largely due to significant layoffs in the federal service, the region’s biggest employer), resale apartment condominium prices have, simultaneously, nearly tripled over the past 15 years. Since the market peaked in 2010, however, increasing prices have run parallel to decreasing sales.



Despite the fact that condominium inventories remained high in 2016 (with a fraction of the 1,200 units still under construction expected to remain unsold), condo starts were still predicted to continue to increase by 27.5 percent in 2017 (CMHC, 2015; McIntyre & Wiebe, 2016). As Ottawa's affordable housing crisis continues to swell while high-priced, newly built condominiums sit unsold, the municipal government's continued focus on capitalistic urban intensification provides a neoliberal outlook for the city's transforming socio-spatial environment.

### **Ottawa's small-n neoliberalism**

Although many of the socio-economic changes that Ottawa has undergone in recent decades are similar to other North American cities of its size, the city has several distinguishing features that make its scope, timeline and policies around urban redevelopment specific to the area. While many municipalities and major metropolitan areas across Canada found themselves in a state of flux and turmoil following the economic downturn of 2008, for instance, Ottawa remained relatively unscathed, due to its existence as a "government town" and booming technology hub. Though significant cuts to the federal service have occurred in recent years, the federal government is still a large, stable employer, with 130,900 of Ottawa-Gatineau residents working as public servants (McIntyre & Wiebe, 2015). The relatively stable job market, compounded with the visible absence of a significant manufacturing and industry sector has made the city much less vulnerable to boom and bust cycles and major economic downturns. With some of the highest disposable incomes in the country and the highest median total income amongst families for all metropolitan areas in Canada (CCHRCO, 2014), Ottawa is also much better equipped to deal with the elements of a recession's aftermath (Adam, 2008). Urban redevelopment projects and policies began to spring up in a noticeable way soon after the region's 2001 amalgamation, and while other metropolitan markets across Canada slowed following the 2008 economic downturn, Ottawa became one of the most attractive places for investment and redevelopment.

In addition to the job and economic stability that it offers, Graham et al. (2001) argue that as the nation's capital, the impact of the federal government on Ottawa's regional development has also been "pivotal". A glorified "tourist town", Ottawa has long suffered from a lack of urban planning vision for its actual residents, and has been subject to a scale of outside investment and development projects that can only result from a city's municipal urban development plans

largely existing in federal hands. No greater example of federal influence over systemic urban planning likely exists than the National Capital Commission (NCC), the federal Crown Corporation responsible for the planning and use of government-owned land in Ottawa. The NCC's handling of Ottawa's LeBreton Flats neighbourhood may be one of the most poignant examples of Ottawa's history of neoliberal urban planning and top-down federal influence on local conditions.

### **A federal vision for municipal space**

In April 1962, the federal government sanctioned the acquisition of the LeBreton Flats neighbourhood (located in the Somerset West ward in central Ottawa) by the NCC without consent from the neighbourhood's 270 property owners. The largely working-class area residents learned that they were being evicted so that the land could be expropriated, largely to build a new National Defence headquarters, and to make "the capital into a showcase for the nation in time for Canada's centennial in 1967" (Picton, 2010, p.316). Claiming that the NCC expropriations were a "brutal invasion and disregard of civil rights" (Picton, 2010, p. 318), Ottawa's mayor at the time, Charlotte Whitton was one of the first – and loudest – voices to express how the NCC's plans did not address the needs of Ottawans, and how the body refused to accept accountability for the city's ongoing housing crisis. During the 1964 mayoral election, Mayor Whitton was quoted as saying that the NCC's involvement in urban planning, "especially in the case of the Flats, put large-scale beautification of the capital ahead of the pressing housing needs of Ottawa's residents" (Picton, 2010, p. 318). Amid contestations, the 1962 demolition of LeBreton Flats went ahead, despite the fact that the National Defence headquarters were ultimately constructed across the Portage Bridge, in Gatineau, Quebec.

Following the mass eviction of its residents in the 1960s, the land of the LeBreton Flats neighbourhood stood vacant for more than 40 years (Picton, 2010). Talks around redevelopment went on for decades without reaching fruition, until a NCC-initiated competitive process was launched in 2014 to "leverage public lands to enhance the attractiveness of the National Capital" (NCC, 2015). This resulted in two competing bids finally being put up for consultation in January 2016. Despite ongoing pushes for years by area city councillors and housing activist groups in the city to dedicate at least a portion of the eventual LeBreton redevelopment plans to affordable

housing, the two final tourism-centric proposals instead promised NHL-calibre stadiums, hotels, museums, and more condominium projects, aligning with the City of Ottawa's continued focus on beautifying the built city. With the NCC being the largest landowner in Ottawa (the NCC owns and manages more than 11 percent of all lands in the Ottawa region, and owns an additional 1,600 properties in its real estate portfolio), and its "beautification" and redevelopment projects primarily focused on attracting tourists, a large portion of the city's urban land is inherently exclusionary of the needs of the city's actual residents. This significant land ownership by the NCC is especially problematic as affordable housing becomes increasingly scarce in Ottawa, and previously vacant, centrally located land is redeveloped exclusively for the privileged.

With developments like LeBreton now underway, and condominium starts expected to continue to rise 27.5 percent in 2017 (McIntyre & Wiebe, 2016) – mainly in the city's downtown core – the relative stagnation of the rental vacancy rate (3.0% in 2017; 3.2% forecast for 2018) indicates a continuing housing crisis in Ottawa (CMHC, 2017). As rental prices continue to simultaneously rise, a much slower uptake of newly built apartment units than anticipated could mean future conversions into condominiums (CMHC, 2017). Meanwhile, many of the new condo units built from 2010 - 2015 (which represent just over 80 percent of total apartment construction in Ottawa during those years) currently sit empty. These units take up important space that could be dedicated to affordable housing for the city's 530 residents living on the streets and 6,705 living in shelters. Currently, there are approximately 22,500 available public and subsidized housing units; and 10,052 clients on the housing wait list (COH, 2016; CMHC, 2015). With the downtown core becoming increasingly dense through condo developments, LeBreton Flats was the last major piece of vacant, central land that could have been leveraged for dedicated, inclusive use.

### **Ottawa's next 10 years: Condos versus care?**

As vulnerable populations in Ottawa continue to experience displacement pressure and community disintegration as a result of neoliberal urbanization, it becomes important to understand what intersecting factors have rendered certain citizens most susceptible to gentrification in the first place. Through this understanding, it will be possible to identify some of the new barriers to health and social services that are emerging as a result of rapid socio-spatial changes.

Though major redevelopment projects in Ottawa have been recent – and arguably minor, when contrasted with other condo-saturated urban centres such as Toronto and Vancouver – projects planned for the nation’s capital in the next decade will likely see the city undergoing some of the biggest changes it has ever faced. At the centre of the city’s urban overhaul is an influx of government-sanctioned redevelopment, which is expected to transform and further privatize Ottawa (Ditchburn, 2016). Between the NCC-led redevelopment of LeBreton Flats, a CAD\$2 billion light-rail line slated for completion by 2018 (largely built to alleviate congestion on the roads caused by the large number of suburbanites who travel back and forth to the downtown core during the week for work), a steady influx of urban condominium projects, and increasing redevelopment policies focusing on “beautification”, places for vulnerable populations within Ottawa’s downtown core are quickly – and problematically – disappearing.

## **Chapter 2: Shrinking geographies of care in neoliberal neighbourhoods**

Here in the community, there have been cuts to housing loss prevention workers in favour of Housing First subsidies [in recent years]. That's an issue – and it's too bad that it's an “either/or” instead of an “and”, because giving people housing without support is not very useful if you're going to try and help the people with the highest needs. [...] What happens is that once our clients stabilize and they find housing, that housing is always outside the downtown core. So then they have to replicate the same pattern of civil servants or students, and come downtown anyway for soup kitchens [and other supportive services].

(Chris, CHC case manager)

Within Ottawa's downtown core, the actions of urban managers (through institutions like municipal government) in a widespread neoliberal milieu are currently restructuring social and spatial landscapes at the expense of the needs of the city's vulnerable populations. While the 'Housing First' strategy, for instance, claims to alleviate homelessness and address affordable housing issues within cities, the one-pronged nature of this approach cannot ensure empowering outcomes for those in need. Housing First may ensure a roof over the heads of some, but it fails to acknowledge the other oppressions and diverse needs facing those rendered homeless or vulnerably housed due to gentrification.

Though this study seeks to explore the oppressive impact of gentrification on social service delivery and accessibility within downtown Ottawa neighbourhoods, an intersectional approach to analysis also involves a confrontation of the overarching power structures that have made certain populations particularly susceptible to the unjust impacts of gentrification, and an exploration of what socio-spatial conditions are required for social/health justice to be achieved. In order to more wholly understand the scope and conditions of marginalization within gentrifying neighbourhoods, it is important to first discern how federal, provincial and municipal structures of neoliberalism produce particular oppressive discourses, policies and conditions that enable gentrification to unjustly impact health and social service delivery.

### **Federal and provincial restructuring and the downloading of responsibility for care**

Throughout Canada, thirty years of neoliberal restructuring at the federal, provincial and municipal levels has led to the adoption of pro-market practices across all sectors; social services

included. Beginning in the 1970s, a transformative shift occurred across all levels of government, where previous, Keynesian-era social responsibility for citizens was replaced by neoliberal policies related to economic de-regulation, the privatization of state-owned enterprises and services, and the roll back of state interventions (Knight & Rodgers, 2012). Largely associated with three main tenets – individualism, privatization and decentralization – neoliberalism promotes the idea of a “laissez-faire” and minimalist type of government, under which, citizens are viewed as consumers whose worth is measured by their capacity for “self-care” (Brown, 2006; Finn, 2007). According to Harvey (2007), neoliberalism, as a political economic theory, proposes that the well being of a country and its citizens “can best be advanced by the maximization of entrepreneurial freedoms within an institutional framework characterized by private property rights, individual liberty, unencumbered markets, and free trade” (p. 22). The strategy for “well-being” that neoliberalism promulgates, however, advantages only a small set of privileged citizens. As economic competitiveness consistently earns top billing in political agendas, those vulnerable populations who have historically and systemically been marginalized within society (and largely dependent on social services) stand to experience further subordination and health inequalities due to unequal access to resources within urban landscapes (Brenner & Theodore, 2002; Cornea et al., 2017).

In response to the significant cuts to welfare and the handoff of responsibility for social service delivery by neoliberal governments in the 1970s, non-profit social services grew rapidly. The advantage of this sector’s involvement in publicly supported services became largely evident, in its “ability to be innovative, flexible, non-bureaucratic and close to the communities in which [programs and services] operate” (Evans et al., 2005). In a socio-economic landscape where populations were becoming increasingly disconnected and marginalized from government supports, institutions like CHCs offered a sense of connectivity, alongside health and social programs that embodied an ethics of care. As 21<sup>st</sup> century gentrification is now leading to increased marginalization for certain populations, the need for community-based care is arguably, more critical than ever. However, as the need for diverse services continues to grow, CHCs in Ottawa are becoming increasingly limited in terms of their capacity to actually deliver services (from a resource-based perspective), and their ability to resist overarching, neoliberal discourses. To better understand how neoliberal practices and local conditions interact to produce small “n”

neoliberalism (Wacquant, 2012) and health inequalities in Ottawa, the political restructuring that has occurred through the Ontario provincial government must first be confronted and analyzed.

Though health and social service spending in Canada has traditionally been a federal and provincial responsibility, the burden has become increasingly downloaded to local governments with limited resources, who have been unevenly implementing their own austerity measures over the past few decades (Fanelli, 2014). In Ontario, for instance, when the Progressive Conservatives took provincial power in the mid-nineties, Premier Mike Harris and his government quickly began initiating radically neoliberal policies. These policies included the massive handoff of numerous provincial social programs to municipalities in Ontario, along with a series of mandated municipal amalgamations (including Ottawa's transformation into a megacity in 2001). From the time that Mike Harris came into office in 1995, until 2001, the number of municipalities in Ontario was reduced from 815 to 447, creating a much more hierarchical system of policy-making than had previously existed. This political restructuring "involved a massive devolution of program spending and responsibilities onto municipalities" (Fanelli, 2014, p.11), which meant a shift in hands in regards to the delivery of many social and health care services. While the Progressive Conservative government at the time argued that amalgamation was in the best interest of Ontarians from an economic perspective, this provincially-mandated restructuring and centralization meant a further move away from municipal governments' ability to represent the diverse and growing needs of local populations. For those already experiencing diverse oppressions, the changing socio-political environment brought on by amalgamation meant increased marginalization for those already encountering barriers within their respective neighbourhoods. Through increased privatization of services, the actions and needs of the wealthy became further prioritized, while an "attack on welfare state provisions" (Walks, 2009, p.346) was simultaneously carried out.

Following the global economic recession in 2008, vulnerable populations in Ontario and across Canada have become disproportionately affected by neoliberal discourses, which have "expanded quickly and abruptly through the implementation of austerity measures" (Hande & Kelly, 2015, p. 962). According to Fanelli (2014), the continuing shift towards neoliberal policy-making at both federal and provincial levels "is putting unbearable pressure on Ontario municipalities" (p.5). Under the current tax system, the province's municipalities collect just eight cents of every tax dollar, leaving a significant gap between the services that local governments are

now responsible for providing and their ability to fund those services (FCM, 2012). With shrinking revenue flow, but more downloaded municipal responsibility for infrastructure and public policies, Canadian citizens are becoming increasingly responsible for self-care at the same time that growing socio-economic and socio-spatial barriers are putting health and social services out of reach for many. In Canada, neoliberal policy shifts have meant a “roll-back of the welfare state and the downloading of responsibility for service delivery and expenditures (Walks 2009, p.346)”. These shifts have effectively restructured municipal bodies to be architecturally incapable – by design – of fulfilling the needs of society’s most vulnerable:

Part of the problem as it relates to Canadian cities involves the ‘mismatched rescaling’ of resource-allocation capacities and responsibilities (often downloaded) and decision-making processes (often retained by upper levels of government), which produce ‘hollow’ local governments rendered fundamentally incapable of fulfilling their new responsibilities (Walks, 2009, p. 346).

With responsibility for health and social services provision largely downloaded onto municipalities, the infiltration of neoliberal policies and lack of available resources have meant a push towards more “efficient” local governments, which prioritize private, free markets “as the solution to social problems and [embrace] of the role of government to promote individualized competition and market-based policies” (Lyon-Callo, 2004, p.10-11). Although devolution and localization appear, in theory, to give more autonomy to municipalities to shape policies around the citizens of their particular regions, in practice, it means “greater risk and responsibility for localities, leaving them little choice but to impose market rule as the “solution” to urban problems” (DeVerteuil, 2006, p. 110). The previously mentioned example of Housing First shows how municipally run social programs risk marginalizing already vulnerable populations through their failure to consider diverse health and social needs.

Justice is unlikely to be served without simultaneous consideration of three dimensions: Redistribution, or targeting material inequalities; recognition, or targeting injustices that stem from cultural differences, and representation, which involves addressing political power imbalances (Klodawsky, 2010, p.6).

While Housing First strategies, in principle, seek to secure permanent housing for vulnerable populations, simultaneous cuts to social services by local governments thwart these initiatives, as



they fail to confront the numerous injustices faced by marginalized populations, apart from being vulnerably housed. Without consideration for the diverse needs of those populations who require access to stable housing, the Housing First model could actually subject vulnerable populations to *new* oppressions, if they are housed in neighbourhoods where they become cut off from public transit, particular CHC services, or other community supports.

According to frontline social services worker Erica, the municipal government's ongoing re-allocation of funds from community-based services to municipally-led programs often simply swaps out one oppressive barrier for another, and fails to confront the diversity of need that exists amongst homeless and vulnerably housed populations. Erica said that she has observed firsthand how the City of Ottawa's Housing First initiative has had a detrimental impact on social service delivery to vulnerable populations across the city. She said that the program has created a resourcing gap within her centre – even though her centre has not directly experienced significant funding cuts:

What [the City of Ottawa] essentially did was they took away dollars from the outreach workers at *many* locations across the city, which is a huge shock for folks living on the street. The plan is to re-allocate those dollars towards Housing First somehow – it's not clear to me at this point how. So that has huge repercussions, because the rooming house workers are gone, so now our centre's nurse is going with the nurse at [a neighbouring CHC] to rooming houses. That's something that's new as a result of that re-configuring of dollars [...] an example of like, when stuff is gone, we fill the gaps.

Though smaller, grassroots centres are often those most directly impacted by funding cuts and neoliberal policies, three of the social service workers interviewed (who are based out of two larger, more robustly-funded CHCs) expressed how cuts to neighbouring programs and services have meant limitations to their own capacity for service delivery, through loss of community ties, partnerships and cooperative resourcing. When the City of Ottawa significantly cut funding in 2015 to Centre 507, a local Centretown drop-in program (the centre's annual budget was slashed from \$650,000 down to \$350,000) (Pearson, 2015), nurse practitioner Jennifer, who is based out of a nearby CHC, said that she directly felt the impact of these external cuts:

[Centre] 507 was *directly* impacting me, because I used to do outreach with one of their workers – either Sarah or Gail<sup>1</sup>...[we] kind of rotated doing outreach together, because they were the rooming house support people, and now they're no more. They would also get things like winter boots – like, this year, people have asked for winter boots, and thank goodness it was a mild winter, because I don't have any access to winter boots or coats.

Similarly, other municipal cuts made in 2015 to the HIV/AIDS and Hepatitis C prevention programs offered through Ottawa's Youth Services Bureau resulted in the loss of three staff positions due to gaps in funding (Ascah, 2015). This resourcing gap appears to have put additional pressure for youth services delivery on a neighbouring CHC, located in the Byward Market/Sandy Hill area:

What we noticed just recently is a little bit of a younger cohort coming in. So we'd always been in the 30-55 range here...and now we're seeing some of the 20-30 folks coming in. These are folks transitioning out of the youth system and coming into the adult system, and we're the closest thing to the youth system I think you can get (Rob, harm reduction program director).

As demonstrated by the narratives above, increasingly prevalent neoliberal policies and cuts to social services funding means that the downloading of responsibility for social service provision does not stop at municipal governments. Instead, it extends further down to the social service organizations themselves. In each of the interviews conducted with study participants, one of the common threads that emerged was the importance of collaborative, inter-organizational partnerships, where local resources, programming and staff are often shared to provide more diverse and robust care to marginalized clients. With many grassroots services continuing to experience funding cuts, however, the burden of responsibility for service delivery and resourcing is becoming increasingly placed on CHCs. As a result, the capacity of these centres to meet the growing and diversifying demands for services is diminishing. Under the current, neoliberal climate, the consequences of even small service cutbacks within CHCs are amplified for clients. According to Jennifer, for instance, cuts to the free bus ticket program at her CHC have meant that many vulnerable populations with limited mobility can no longer feasibly travel to get blood work done, or to pick up groceries.

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<sup>1</sup> Names have been changed

As resources become increasingly drained across the social services landscape, larger CHCs in Ottawa are faced with the difficult task of filling the gaps in service delivery left by the closure or cuts to funding of smaller centres and grassroots organizations. This strain on resources limits CHCs' capacity for service delivery to those impacted by gentrification, and forces centres to prioritize the delivery of certain programs or services over others.

### **Re-organizing the city and its subjects through converging neoliberal and neoconservative discourses**

Beyond significant austerity measures and increasing privatization of formerly public health and social services, neoliberalism as a political rationality also involves "a specific and consequential organization of the social, the subject, and the state" (Brown, 2006, p. 693). In the context of North American cities, the production of a particular political culture and subject is propelled by a "state-led and -legislated moral-political vision" (Brown, 2006, p. 697), through which neoliberal governments concerned with preserving the declining state of "morality" in the West frame dependency on services and redistribution as "a wrong against the middle class" (Brown, 2006, p. 701). Within gentrifying Canadian cities in the 21<sup>st</sup> century, particularly, neoliberalism and neoconservatism converge through government agendas to reorganize the city and its subjects in oppressive ways.

While neoliberal agendas that reduce government intervention and emphasize individual responsibility have been generally followed globally since the 1980s, the election of Stephen Harper's Conservative government in 2006 resulted in the establishment of many neoconservative goals within Canada (Porter, 2012). With goals that appear to be somewhat contradictory to neoliberalism, neoconservatism emphasizes social order and morality, resulting in the exacerbation of inequalities among and between marginalized populations. In the context of the gentrifying city, neoconservatives manifests through an increased "law and order agenda" (Porter, 2012, p.24), which can potentially curtail the rights of vulnerable populations – including their right to the city.

According to Lefebvre (1991), the power to appropriate urban space and have a say in decisions about urban development belongs to neighbourhood residents. What he originally conceptualized as a unified, resident-centred approach to conceiving and producing urban space, however, now exists in a 21<sup>st</sup> century capitalist context as a zero-sum game where "urban residents are reduced to competing with each other, not with an economic system" (Balzarini, 2015, p.514). Through the

convergence of neoliberalism and neoconservatism within gentrifying neighbourhoods, “the rights of those with economic power are assumed and their wants and needs often automatically supersede those of long-time [neighbourhood] residents” (Balzarini & Shlay, 2015, p. 504). This inequitable spatial production and community change can be analyzed as a continuing interaction of neoliberal policies that redevelop exclusive spaces for the wealthy, and neoconservative discourses that simultaneously banish “disorderly” individuals from these new, privileged urban landscapes (Jefferson, 2016; Porter, 2012).

At the convergence of neoliberal and neoconservative rationalities, argues Brown (2006), four “de-democratizing” effects exist:

(1) the devaluation of political autonomy, (2) the transformation of political problems into individual problems with market solutions, (3) the production of the consumer-citizen as available to a heavy degree of governance and authority, and (4) the legitimization of statism. (p. 703)

The interaction of a neoliberal economy (where the responsibility for health and social well-being shifts onto the individual) with a neoconservative rationality (where government discourses closely regulate and oppress inter-dependent bodies) creates a dangerous political and social environment. Here, citizens who do not demonstrate “value” to society in a very narrowly prescribed, economic sense become systematically excluded from it. Through neoconservative policies, communal space within urban landscapes becomes forcibly divided into inside/outside binaries, as vulnerable populations such as panhandlers, sex workers, homeless individuals and drug users are systematically removed from public space by law enforcement, and marginalized by more privileged neighbourhood residents (Jefferson, 2016). City-led redevelopment policies or Business Improvement Area initiatives to “beautify” spaces often result in rendering invisible the bodies of “undesirable” populations through accompanying, neoconservative discourses.

Though towering glass condominiums, expensive storefronts and a particular style of streetscaping are all general features of gentrification across North America, the way in which neoliberal and neoconservative discourses manifest through specific urban landscapes cannot be reduced to one blanket understanding. In order for CHCs and other service delivery organizations to achieve health and social justice for clients in the face of gentrification, local conditions (both on the municipal and neighbourhood level) must be analyzed and understood. According to

Akçalı & Korkut (2015), the reproduction of neoliberal discourses within cities has become largely dependent on urban planning strategies and local political conditions. Cities, they argue, “have become key institutional arenas in and through which neoliberal governmentality is insinuating whilst urban transformations reduce lived spaces to commodities to be consumed” (Akçalı & Korkut, 2015, p. 78-9). As public space becomes increasingly privatized in urban areas across Canada, the different types or degrees of social injustices and inequalities being produced vary, depending on the particular socio-spatial context. This embodies Wacquant’s (2012) idea that there is no “big-N” form of neoliberalism – but instead, an indefinite number of “small-n” forms, which call for diverse, social justice-oriented solutions. At the same time, several scholars (Hatt et al., 1990; Ratner & McMullan, 1985) have also argued that the Canadian brand of neoconservatism is less well defined and more localized than in other countries. Under this “actually existing neoliberalism” (Walks, 2009, p. 346) and neoconservatism, oppressive and inequitable policies rolled out by governing bodies are implemented unevenly – and at times, haphazardly – meaning that vulnerable populations can experience marginalization differently, depending on their geographical location, health status, socio-economic status and more. In order to achieve justice for these citizens, then, an analysis of the “array of differences constructed in cities” (Fincher & Iveson, 2012, p.234) needs to be taken into account by policy makers, urban planners and CHCs alike, through their respective planning processes.

Hasenfeld and Garrow (2012) argue that the devolution and privatization being produced through discourses of neoliberalism have impacted the overall politics of care within cities, claiming that “the state and its bureaucracies would be more responsive to citizens if entitled services were devolved to the local level and subjected to market principles” (p.304). By downloading responsibilities for services to local authorities, however, the roll-out and funding for social programs and services then becomes contingent on the local political environment. Here, municipal governments often use the principle of small-n neoliberalism to “embed their own moral values, ideologies, and interests in the structure and practices of the social services they control” (Hasenfeld & Garrow, 2012, p. 304). In Ottawa’s case, this has resulted in policies, programs and examples of governance that are inherently at odds with the needs of the city’s most vulnerable.

In 2007, then-mayor Larry O’Brien infamously cancelled the municipally-led safer inhalation program, which was initiated to provide free, clean crack pipe kits to drug users to mitigate the

spread of disease (City of Ottawa, 2007). The Ontario Ministry of Health and Long-Term Care eventually stepped in to save the program, providing \$287,000 to Somerset West Community Health Centre (SWCHC) to continue distributing kits for 12 months (CBC, 2007). Ten years later, the safer inhalation program is still being run by this CHC, without support from the local government. This example shows effective downloading of responsibility for harm reduction from the public government onto a private service provider with limited resources. It also shows how the downloading of responsibility for health services required citywide can result in the concentration of important health services within a particular neighbourhood only; one that is not necessarily accessible by all populations requiring resources.

Similarly, in 2017, Mayor Jim Watson pledged to move at least one of the three homeless shelters located in Ottawa's Byward Market to a different geographical location, arguing that the proximity of these shelters to each other is problematic for those who frequent them. "It's not taking a problem and moving it to another neighbourhood. It's taking these people out of a problem situation and giving them a real shot at trying to recover from some of the challenges that they're facing," he said during a press conference in February 2017 (CTV Ottawa; 2017; Nease, 2017). With no accompanying announcement about how the city might address the gaps in health and social service delivery that would likely arise from displacing homeless individuals from a central location, the burden of responsibility for care is once again pushed off the municipal government, and onto the city's already under-funded social service organizations. The timing of Mayor Watson's announcement is also significant: As the city's central tourism hub, the Byward Market underwent rapid business/residential redevelopment projects leading up to Ottawa's year-long celebrations of the 150<sup>th</sup> anniversary of Confederation in 2017. The decision to further "beautify" the neighbourhood by banishing some of the "disorderly" (Jefferson, 2016) individuals who had not yet been displaced by gentrification functioned to affirm the city's aggressive neoliberal/neoconservative agenda and continuing dissolution of an ethics of care for citizens. Moving one of the city's largest homeless shelters away from a central tourism spot emphasizes how current municipal policies are principally focused on economic gain, rather than on the health and livelihoods of Ottawa's vulnerable residents. This oppressive municipal decision also stands to put an increasing burden on surrounding social service providers, who would shoulder the gaps in care that would arise from emergency shelters becoming physically out of reach for many of the homeless individuals who occupy Ottawa's downtown core.

## **Neoliberal governmentality and a shifting ethics of care**

While neoliberal discourses can negatively impact health and social service delivery through funding cuts and displacement, growing injustices are also being produced for the vulnerable populations who continue to live in gentrifying neighbourhoods. According to Klodawsky (2010), there are two recent trends in downtown urban redevelopment that can be largely linked to the production of exclusionary discourses and the shrinking ethics of care that reduces neighbourhood residents to their economic value.

On the one hand, pressure is growing for municipal governments to attract economically productive activities in order to help pay for services previously provided by senior levels of government. On the other, disciplinary practices that attempt to reduce the visibility and the assumed negative impacts of less attractive populations and activities are also on the rise (p.14-15).

While neoliberal discourses position social and financial independence as markers of success, those who continue to require access to social welfare programs are often subject to self-blame and exclusion, and are framed as having no value to society (Peacock et al., 2014). Because care is not motivated by self-interest and cannot maximize profits, argues Held (2002), it thus has no value in a political climate where only economic value matters: “From the perspective of the ideal market, values that cannot be reduced to market values are flaws – interferences with rationality and free exchange. Social relations such as trust and caring are invisible” (p.25). As a result, any policies oriented towards vulnerable populations or representing an “ethics of care” become generally absent from senior government agendas (Baines, 2015; Klodawsky et al., 2006; Williams, 2001).

One of the most dominant and oppressive discourses existing within neoliberal urban environments perpetuates the idea that care belongs to the private domain exclusively, and that justice is an independent value that falls under the public, political domain. Through this discourse, the provision of care and the provision of justice do not interact (Held, 1995). Harm reduction program director Rob provides one example that demonstrates a potentially problematic outcome resulting from this separation discourse, in an Ottawa-specific context. Below, Rob recounts his experiences with local police in regards to his CHC’s efforts around establishing a safe injection site for drug users:

Police services generally serving North America aren't usually big fans of [harm reduction] interventions [...] even in Vancouver they support it, but they really focus on the public safety; they try not to get involved with the health aspect of things. [Here in Ottawa], the police basically have said "we don't want to be a part of any planning for this, however when you're done and you've got your model [...] you can send it off to the Chief of Police and he will respond on the public safety aspects of your application".

Based on his experiences with police, Rob observes a clear line drawn between the provision of care and justice. Here, he expresses concern that police in Ottawa view the maintenance of public safety to be their sole responsibility, without consideration for the danger that drug-using populations face by not having access to equitable care. Within this neoliberal and neoconservative climate, the definition of "public" appears to be homogenous and essentialized, and fails to include vulnerable populations. Through this concept of public safety, the "protection" of the privileged can result in the further health and social oppression of the city's most marginalized residents.

Instead of seeing care and justice as separate ideals, argues Held (1995), government bodies need to think of human welfare from a perspective of justice, equality and rights, so that care becomes recognized as "something to which each person is entitled by right under conditions of need" (p.129). If barriers to accessing care exist, this perspective holds, then injustice exists – and ensuring justice for citizens should be the goal of a country's governments. Integrating this sort of ethics of care into public life and policy is paramount to achieving social justice, argues Williams (2001), as it values the capacity for self-determination over the expectation of individual self-sufficiency: "[An ethics of care] recognizes that vulnerability is a human condition and that some people are constituted as more or less vulnerable than others, at different times and in different places (p. 487)". Under this definition, "care" is no longer essentialized or sentimentalized to refer just to individual emotions, but is viewed instead as "a practice and politics" (Lawson, 2007, p.5) central to every aspect of human life. While personal autonomy is still valued through an ethics of care, achieving social justice means that that autonomy must be developed and sustained within frameworks of care and relations of trust (Held, 1995). Under this type of framework, care is seen as "endemic to (potentially) all social relations that matter" (Lawson, 2007, p.3). The maintenance of these frameworks of care is part of the reason why accessibility to CHCs and other community-based services is especially critical within a neoliberal/neoconservative urban



landscape. By offering important health services in an environment where community engagement is also possible through things like social programs and employment resources, says Rob, clients can experience both autonomy and equitable access to health care and other social services:

[Clients] want to be involved and they want to participate in and give back to society – they really do, even while they’re actively using drugs. So we need to do a better job of finding ways of accommodating that for people – because as people get more engaged, they’ll naturally take better care of their health. Because I mean, if you’ve got nothing to live for, then you’re not going to be that concerned about having Hepatitis C or HIV.

In addition to framing interdependence as the basis of human interactions (Williams, 2001), an ethics of care is critical within social service delivery, as it recognizes that policies and programs shaped around the provision of equitable care must also take into account the different oppressions that particular vulnerable populations are facing at any given time, in any given place:

Caring for person-to-person relations involves understanding how difference is socially constructed, and so a critical ethic of care must be coupled with analysis of the structures and institutions that reproduce exclusion, oppression, environmental degradation, and the like (Lawson, 2007, p.7).

In the context of this research, an ethics of care framework is important to apply, as gentrification and neoliberalism interact in different ways in different cities and different neighbourhoods. It is thus important to understand how these interacting processes of oppression uniquely affect health equality in Ottawa, and create barriers and challenges for both health providers and the vulnerable populations they serve (Murphy et al., 2008; National Academy of Medicine, 2016).

In order for CHCs and other community-based social service organizations to be able to ensure equitable health outcomes for their vulnerable clients in the face of gentrification, an ethics of care *must* be incorporated. This includes taking into consideration how one’s socio-spatial environment impacts their overall health. As it stands under current municipal governance, self-sufficiency of citizens has increasingly become the goal of social life (Klodawsky, 2010), as the neoliberal process of “responsibilising” citizens simultaneously works to “irresponsibilise” governments and institutions of providing care to individuals (Cradock, 2007). Understood in this

context as “the self-management of risk by the autonomous individual” (Liebenberg et al., 2015, p. 1008), “responsibilisation” results in significant tension and challenges for frontline workers at CHCs, who are increasingly finding themselves positioned between an overarching system that encourages self-regulation and their clients who require support and interventions (Liebenberg, 2015; Juhila et al., 2016).

As social service organizations become increasingly focused on accountability to stakeholders and managing societal and/or organizational risk, vulnerable clients who access services become “re-imagined as individual consumer[s] who must be encouraged to become more responsible for his or her behaviour” (Woolford & Curran, 2012, p. 54). Through these neoliberal systems and organizations, there becomes a ‘right way’ and a ‘wrong’ way to interact with social services. From a health care provision aspect, for instance, clients who are able to comply with the rules and boundaries of things like drug counselling, scheduled appointments and social programs are seen as successfully engaged. Meanwhile, those who run into barriers accessing services (either physical or social) are seen as unworthy or undeserving of receiving care altogether (Gray et al., 2015; Liebenberg et al., 2015). Frontline worker Erica affirms that this exclusionary, binary method of categorizing individuals as either “acceptable and deserving” or “unacceptable and undeserving” of care has seeped down from overarching, neoliberal discourses, and into her own CHC in recent years:

When [I’m] doing outreach in the community to promote our services, I’m always mindful of the fact that we’re not actually really set up to welcome a lot of the folks I’m outreaching to. So it’s not even a matter of we don’t make our programs a good fit for them, because you have to come at a certain time – if you come late, its often there’s a lot of shame attached to that, or if you’re loud, or whatever else – but it’s also like, so when they come, if their behaviour is a bit out of what’s considered appropriate, there’s a huge repercussion or consequence, and that makes them feel like shit.

As Erica’s example shows, the detrimental impact of neoliberalism on service delivery goes far beyond cuts to funding, as oppressive discourses become manifested through increasingly rigid and homogenous programs within her CHC. Within this shifting landscape of care, Erica has perceived that the community-based programs and services offered by her CHC are more so being delivered based on the criteria of whether or not they are economically beneficial – rather than whether or not they ensure an ethics of care. In order to access some CHC programs, Erica

describes, vulnerable populations must alter their behaviours to fit a homogenous, privileged model of service delivery, through which their diverse needs may not necessarily be addressed. Under a dangerously dichotomous model such as this, social services become more and more aligned with overarching neoliberal discourses, as organizations place responsibility for care on the individual instead of holding government bodies responsible for Canada's steep health gradient (Shapcott, 2012). In cities and gentrifying urban centres in particular, inequalities between the privileged and the marginalized have become especially pronounced as a result of recent neoliberal policy-making. Through processes of rapid gentrification, "the appearance of locally specific segregation [has perpetuated inequality] through master-planned, privatized communities and the ever-greater decline in the physical fabric and social support of poorer localities" (Fincher & Iveson, 2012, p.235).

Though Baines (2015) argues that Canadian health care has always been a bureaucratic process, recent years have seen the increasing rise of neoliberal discourses within health care provision. This is a problematic trend in the context of gentrification, where growing socio-economic gaps between the haves and the have-nots become perpetuated at the neighbourhood level, resulting in a shift in (and expansion of) the needs of CHC clients. To government bodies, health is mostly seen as purely 'medical', while a more intersectional understanding of health (including the 'well-being' aspect) is largely absent from any discourse or practice (Baines, 2015). One's mental health and sense of empowerment can be greatly influenced by their ties to the community, for instance, and displacement from that community can have an extremely oppressive impact on their overall wellness (Egan et al., 2015). Under an increasingly one-tiered approach to health care delivery, "many social justice concerns are ignored in favour of providing standardized interventions aimed at meeting the 'average' needs of the 'average' Canadian" (Baines, 2015, p. 196). As social service provision shifts to accommodate the physical and demographic homogeneity of gentrified neighbourhoods, vulnerable populations who manage to avoid physical displacement become at risk of facing new health oppressions.

### **A privatized and punitive city**

According to Kaplan-Lyman (2012), the growing shift in North America towards increasingly neoliberal policies and practices "has led to lasting changes in the accountability structures, enforcement priorities, and policing strategies" (p. 177) in cities. This shift has functioned to

create a largely punitive state, which focuses on incarcerating those suffering from systemic inequalities, rather than trying to empower them through equitable access to social services. Though neoliberal governance is principally associated with the *handoff* of responsibility for social services and the emphasis on independence of citizens, the targeted, neoconservative exclusion and punishment of interdependent vulnerable bodies within gentrifying neighbourhoods has simultaneously resulted in an increase of government interventions. According to Peck (2001), “a neoliberal state is not necessarily a less interventionist state; rather, it organizes and rationalizes its interventions in different ways” (p. 447).

In addition to the impact felt on their centres and clients as a result of ongoing, neoliberal cuts to social services, some CHC staff members say they have observed oppressive neoconservative discourses also manifesting through increased police presence within the neighbourhoods surrounding their respective centres. As part of the neoconservative movement that advances a shrinking, exclusionary definition of “public” and “public space”, police appear to be exerting additional control and pressure on marginalized populations who access public spaces within gentrifying neighbourhoods. At the same time that critical health and social services are becoming more and more difficult to access from a resource standpoint, the growing policing of public space functions to enact further physical and social barriers to delivery.

According to frontline outreach worker Steve, increased police presence has been clearly observable in the neighbourhood his centre operates within. He said he believes this has caused a significant increase in the self-regulation and invisibility of certain marginalized populations such as sex workers, who have traditionally accessed his centre:

I remember when I first started working here, and lived in [this neighbourhood], it was like, daily, it was very normal at nighttime for women to be out doing work, and now, for the last year, it's totally quieted down. I see a bit more of it now, but yeah, there was like, for a two year period, I think, where you hardly saw anything because of constant police presence.

In the case of the observed disappearance of sex workers in Steve's neighbourhood, the exclusion and displacement of certain populations within gentrifying spaces appears not only to be indirect (i.e. associated with rising rental costs, lack of social service resources and/or the deterioration of community-based networks), but also directly associated with neoliberal discourses, which take a physical form through increased policing.

Harm reduction program director Rob also discussed similar, observable themes of surveillance and punishment in relation to his own centre. In reference to his CHC's ongoing offerings and initiatives around harm reduction services within the community<sup>2</sup>, Rob said that “direct resistance often comes from police services”, and that the unequal power dynamics that officers wield can be detrimental to drug-using populations in the neighbourhood:

We still regularly get reports of [police] taking materials away from people and destroying unused materials [...] they're also resistant to doing a lot of active work with the community [...]. Police are really representing the interests of the wealthy, as opposed to people who have a medical condition, called a substance abuse disorder. That's the most immediate and present threat to [drug-using populations] – it's not the guy in the neighbourhood who doesn't like them; it's the police who are enforcing the unjust drug laws.

While gentrification introduces a new type of privileged subject to previously mixed-use neighbourhoods, neoconservative discourses with a narrow view of “public space” and “public safety” manifest through growing police presence in these neighbourhoods. Though the mere presence of police is often enough for vulnerable bodies to self-displace from increasingly privatized public spaces, for those who put up any sort of resistance to this targeted exclusion, the consequences can be severe. According to Erica, for example, police presence and subsequent criminalization of vulnerable youth populations in the neighbourhood around her CHC has increased to a dangerous degree in recent years:

I've certainly seen an increase in youth coming to me saying, “I've been beaten up by a police officer; I just saw my friend get the shit kicked out of him by a police officer” – like, almost every single youth I've engaged with has come to me with a story like that at least once. So that's new – *for me*, at least – and I think for our centre [...] we never really had that before, so that spike really identifies to me, like, “whoa – they're really trying to get rid of these youth here – they're really trying to scare the shit out of them, or criminalize them, or get them out of this area.

This example can be analyzed in connection with the aforementioned municipal cuts in 2015 to the nearby Youth Services Bureau of Ottawa (Ascah, 2015). Though these funding cuts were quite program-specific, they can be looked at in a wider sense, as a reflection of the current austerity measures faced by most social service organizations in Ottawa, and the impact of neoliberal funding cuts in conjunction with increasing neoconservative discourses around punishment. In this

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<sup>2</sup> Rob is currently spearheading the establishment of Ottawa's first supervised injection site within his CHC

case, not only will some vulnerable youth be at an increased health risk due to cuts to prevention programs, but the threat of increased police presence, violence and criminalization may deter them from accessing certain public spaces – and subsequent health resources – altogether.

In another example, Erica discovered through focus groups held with vulnerable populations who use illicit substances in a local neighbourhood park, that these individuals' primary concerns around their well-being was related to increased police presence in the area:

When we were doing that focus group, police brutality was the main thing, and [participants] said that police presence and bylaw presence in that park has increased like, a million times fold. I addressed this with my manager and we spoke to the community police officer and said, “here are concerns from the community” [...] and he agreed that there was increased police presence. He said that it was because there was, at that time, a real increase – at least from their perspective – of people hanging out on Bank Street panning and drinking in public, and he said that that was because a lot of the ‘clean-up’ that was being done in Sandy Hill pushed a lot of folks up to the Bank Street area.

Through these focus groups, and subsequent conversations with police officers in the area, Erica received confirmation that increased police presence was occurring within the neighbourhood around her CHC. The “clean-up” that the community police officer above is referring to has to do with a particular neoliberal and neoconservative governmentality that systemically and determinedly works to exclude and displace vulnerable bodies from increasingly privileged and exclusive public spaces.

Efforts by police and neighbourhood BIAs (Business Improvement Areas) to “clean up the streets” and rid public space of certain undesirable populations as part of a concerted neoliberal/neoconservative project can be understood through Schaller and Modan's (2005) study of a Neighbourhood Business Improvement District in Washington, D.C. This study looks at how the use or purpose of residential street space differs depending on its users. While more privileged neighbourhood residents consider public spaces like city streets to be areas of consumption (e.g. for shopping or dining), vulnerable populations are more likely to see the same streets as areas for socialization. From a neoliberal perspective, if certain populations are not using these “public” spaces for capitalistic purposes, then those bodies are therefore deemed to be “inappropriately” using said space (Schaller & Modan (2005). This ongoing, concerted effort to “clean up” urban neighbourhoods through police enforcement and other punitive measures as observed in Washington, D.C. can similarly be seen in Ottawa's downtown core. Along Rideau Street for

instance, which runs through the Byward Market and Sandy Hill neighbourhoods (two urban areas occupied by significant concentrations of homeless individuals and large concentrations of social services), new digital signage was erected in 2015 by the Downtown Rideau Business Improvement Area (BIA), encouraging people to report strange or inappropriate behaviours in order to “keep the district clean and safe.”



*New signs erected along the main strip of Rideau Street in the Byward Market/Sandy Hill area encourages passers-by to report any behaviours not perceived as conducive to keeping the neighbourhood ‘clean’ and/or ‘safe’ for a particular group of residents.  
(December 2015; MJ Deschamps)*

As urban redevelopment projects transform the city’s physical landscape, the fear-mongering discourses represented through this campaign simultaneously work to make spaces more socially sanitized for the influx of new, privileged businesses and residents. Though neoconservative discourses such as these are not always stated so explicitly, they function to set the stage for significant, marginalizing socio-spatial changes to occur within neighbourhoods with little to no pushback. “People know that they’re not welcome in these spaces...these zones of exclusion that aren’t necessarily explicit about it, but even the culture within them...makes them feel like outsiders,” said Steve.

Erica said that it has become clear to her, based on dialogues she has had with community police officers and members of her neighbourhood BIA, that the public space surrounding her

CHC is poised to become increasingly exclusive and policed as processes of gentrification continue to accelerate. “[Recently, one] community police officer was referring at a community neighbourhood table to folks who panhandle as ‘undesirables’ all throughout the meeting”, she said, adding that neighbourhood changes led by urban redevelopment groups and the City of Ottawa that emphasize beautification “is code for getting rid of ugly people who represent ugly things like oppression”.

Based on interactions she has had with clients, Erica believes that the overall increased police presence, surveillance and punitive action against “undesirable” populations occurring in the area is having a direct and detrimental impact on the mental and physical health of many vulnerable populations. She shared one particular example to illustrate how growing police presence in urban neighbourhoods can lead to increased oppression for marginalized residents:

One thing that has become a bit more [evident] is the interaction with police and panhandlers. There’s this one woman who is lovely...she’s young, she’s Inuit, she’s had a lot of trauma – she has mental health stuff going on that’s pretty severe and serious in relation to her trauma, [but] she’s a very likeable person; she’s very respectful, she respects police – I don’t know if she’s *ever* been criminalized. That said, this year, she came into my office spiralling in despair, and really feeling suicidal and out of control and needing support because she had an engagement with a police officer. As far as I could tell, it was a respectful engagement in the sense that there wasn’t the typical brutality that is affiliated, or harassment that happens – he was just respectfully enacting the Safe Street<sup>3</sup> act of saying, like, “you can’t panhandle here, if I see you here again, I’m going to give you a ticket, this is a warning”; but he was, you know, probably being a dick. [...] So just by saying “you can’t be here, move along or else you’ll get a punishment”, that spiralled her mental health *severely*, to the point that I had to spend the morning [...] de-escalating her and getting her support, and it really impacted her mental health for a time after that – and she’s no longer coming to this area to panhandle at all, which means I don’t see her.

While the client that Erica describes here previously accessed care at her CHC on a regular basis, the avoidance of police – out of fear of punishment – has become her foremost focus. This has limited her ability to access important mental health services. This example of self-displacement from public space demonstrates the multi-tiered, oppressive impact of neoliberal policies and neoconservative discourses around “cleaning up” the streets. These discourses not only function

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<sup>3</sup> The Ontario Safe Streets Act (SSA) is a provincial law in Ontario (S.O. 1999, CH.8) that came into effect in 2000. The highly subjective and oppressive SSA was enacted to address panhandling, squeegeeing and other forms of solicitation undertaken in “an aggressive manner...a manner that is likely to cause a reasonable person to fear for their safety and security”. The often unjustly applied law overall functions to criminalize homelessness.



to restrict marginalized populations from accessing public space, but also simultaneously restrict their ability to access private health and social services.

The growing barriers to CHC accessibility posed by neoliberal/neoconservative discourses and urban redevelopment policies demonstrate the need for centres to respond with new and intersectional approaches to service delivery. However, according to Erica, social service workers are simultaneously facing barriers themselves, in terms of their ability to adapt programs to respond to the needs of their most vulnerable clients. Increased neighbourhood police presence, for instance, is resulting not only in the penalization and regulation of vulnerable bodies on the streets outside CHCs, but inside CHCs as well:

The Ottawa Police are connected to practically every single social service agency. They sit on boards, they partner, and they provide funding through Crime Prevention Ottawa for ‘beautification’ projects or youth engagement projects. And not to say that those things are bad – I think there’s value in providing resources and giving them to social services versus them running them – but the challenge is then the ability for us to critique, or to provide feedback, or to express concern is squashed.

Similar to her description of the young Inuit woman who chose to leave her neighbourhood due to increased police pressure within public space, Erica’s own experiences with police pressure in private spaces have led her to feel marginalized and powerless in several facets of her own work. She expressed that this has effectively limited her ability to advocate for the needs of her clients. In both instances, it is demonstrated how the policing of public space and private surveillance have introduced new barriers to social service provision in terms of accessibility and delivery.

Beyond the immediate short-term health impacts that can be produced for individuals as a result of increased police presence in neighbourhoods, Rob describes a more long-term effect of the existing, overarching neoliberal/neoconservative governmentality. The current state of punitive governance in Ottawa that Rob describes functions to establish residual social and health impacts, and growing distrust and tension between vulnerable bodies and police:

A couple of years ago, when [a] young woman was murdered in the [Byward] Market – the sex worker – the police were coming around trying to support the community, and to try to get information to find the person who did this, and they were...I don’t know if they were shocked, but, you know – frustrated that the community wasn’t being responsive. And it’s

like, guys – you can't just come here and do this. You can't do the stuff you do to [vulnerable populations] every other day of the year, and expect them to trust you. I know you're trying to help them because someone was killed, but what about everything else?

This example shows that even in those instances where police may be able to lend support to a particular community, it may not be possible due to the ongoing oppression (both real and perceived) of vulnerable populations by punitive figures. Discourses that punish 'bad' behaviours such as drug use have become so pronounced in Ottawa, in fact, that social service workers like Rob believe that for CHCs and other community-based service organizations to make *real* progress in terms of offering equitable services, their most vulnerable clients must often be hidden from public view:

I think most people would be surprised to learn [...] how much we actually do here with the active drug using population that they don't know about. I think that's one of the key issues with moving forward around some harm reduction activities, is that people have this fear about what it's going to do to the neighbourhood; when the real experience if it's well-run is that it doesn't really have much of an impact. And that's definitely our goal – is to be not noticed very much for what we do by our local community. That would be a marker of success for us.

Though operating under the radar may help avoid certain confrontations or pushback from potentially oppressive figures such as police officers or wealthy neighbourhood gentrifiers, an approach to service delivery that renders vulnerable populations invisible runs the risk of perpetuating larger, neoliberal discourses that associate dependence on health and social services with shame and self-regulation. The above is just one more example of how larger neoliberal discourses around self-sufficiency and independence are infiltrating every aspect of both private and public life, as the maintenance of invisibility and punishment of vulnerable populations within the eye of the general public becomes prevalent and normalized.

As processes of gentrification continue to infiltrate downtown neighbourhoods in Ottawa, overarching discourses and policies related to the rapid privatization of space, the increased policing and exclusion of bodies, and the disappearance of an overall ethics of care ensures the creation and maintenance of socio-spatial conditions under which inequitable urban transformation can occur without resistance. Building from an understanding of how the systemic marginalization of vulnerable populations is already occurring within downtown neighbourhoods, Chapter 3 will closely analyze case studies of the interaction of small "n" neoliberalism with case

studies of gentrification in Ottawa to better understand how new health oppressions are being produced as a result of ongoing urban transformation.

### **Chapter 3: Urban transformation and gentrification-induced health disparities**

I don't know about you, but here at work, if I'm going out for lunch...I'm going to go somewhere nearby. So when panhandlers are at work, they're going to work somewhere probably, where there's good traffic – like on Bank Street – but also somewhere where they can go get lunch, like Centre 507, or Ottawa Inner-city Ministries on Tuesdays [for their weekly drop-in]. Or, they can [come see me] to do the paperwork they need to do, or stop by the Ontario Works office, which is really close to here as well. This is the place where panhandlers work because it's convenient for the other things they need to do in their lives, but now, they're being pushed out [of the neighbourhood], and they're losing support. [...] That's an example of a trend that's started – or at least that I'm becoming more aware of – is that people are no longer working here, [and] they're no longer as likely to come and access services here, or elsewhere in the area.

(Erica, frontline social services worker)

For social justice advocates, any measures or methods of governance that significantly restrict the physical movements or social behaviours of vulnerable populations while promoting the neoliberal discourse of “self-sufficiency” are of significant concern (Klodawsky et al., 2006). As Chapter 2 discusses, vulnerable populations in Canadian cities have, for decades, faced many intersecting oppressions due to the growing presence of neoliberal and capitalist policies at the federal, provincial, municipal and neighbourhood levels. Among other things, this has resulted in significant cuts to community-based social services and subsequent barriers to the equitable provision of health care to vulnerable populations. Now, as 21<sup>st</sup> century gentrification projects continue to intensify in downtown Ottawa neighbourhoods, frontline social service workers based out of several of the city's urban community health centres (CHC) are observing new, emerging systems of oppression that are negatively impacting the health of their vulnerable clients. While neoliberal policies and diminishing welfare resources limit the capacity of CHCs to *deliver* care, gentrification projects are simultaneously creating socio-spatial barriers within urban neighbourhoods that restrict *access* to services for those vulnerable populations who have managed to remain physically intact in their neighbourhoods, despite displacement pressure. As frontline social services worker Erica expresses in the narrative above, she sees a critical shift occurring in the gentrifying area around her downtown CHC, where the physical movement and social autonomy of vulnerable populations is becoming increasingly restricted. As gentrification interacts with neoliberal discourses to organize space in a way that is increasingly aligned towards the economic, rather than the social, those populations who cannot contribute to the maximization

of exchange value are no longer welcome within gentrifying neighbourhoods (Balzarini & Shlay, 2016). As a result of these new physical and social barriers, the opportunities for equitable health delivery to vulnerable clients also becomes diminished.

This chapter will argue how gentrification's interaction with neoliberal/neoconservative and capitalistic discourses produces systemic health and social oppressions in downtown Ottawa neighbourhoods. Through an analysis of literature, narratives from social service workers and researcher observations, the following sections explore how Ottawa's particular built environment is changing under "small-n" neoliberal governance; how gentrification is creating physical barriers and socially exclusive public spaces; and how the displacement and disenfranchisement of both vulnerable populations and community-based social services is having an oppressive impact on the ultimate health outcomes of marginalized neighbourhood residents.

### **Gentrification-based displacement and urban demographic shifts**

First coined by British sociologist Ruth Glass in 1964, the term "gentrification" has become an increasingly broadened concept over the years. While Glass' original conceptualization of gentrification has mostly been used to describe the residential aspects of the process, within the context of contemporary North American cities, the concept of gentrification has become more widely attributed to any "transformation of a working-class or vacant area of a city into middle-class residential and/or commercial use" (Lees et al., 2008, p. xv). "Gentrification" as it is known today can encompass everything from redeveloped/newly built residential homes and condominiums, to retail and commercial properties.

Considered broadly to be part of a larger "continuum of social and economic geographic change" (Shaw, 2008, p. 1697), the defining feature of gentrification, cultural consumption, closely aligns with central neoliberal discourses. While it is true that gentrification can take on many definitions and expressions, Shaw (2008) highlights a central, oppressive power dynamic: "One thing is [always] common [within a gentrified neighbourhood] – people who cannot afford to pay are not welcome, and homeless people are moved on" (p.1698). No longer confined to the inner city, processes of gentrification in the 21<sup>st</sup> century intertwine with processes of globalization to intensify geographies of inequality (Lees et al., 2008). Though gentrification is often contextualized in its capacity to work for the neoliberal economy by creating social and financial

capital, the new built environment that it ultimately carves out also functions to create exclusive forms of public space, which are made accessible only to the privileged.

In North America, most urban centres in the 21<sup>st</sup> century have experienced – and are continuing to undergo – significant neoliberal restructuring, where socially vulnerable and economically disadvantaged populations are increasingly being displaced from and/or criminalized within public space. According to Boudreau et al. (2009), through gentrification and intensified social exclusion within urban neighbourhoods, “the middle classes have largely obliterated the spaces of the poor” (p. 20). The resulting oppression and marginalization occurs to varying degrees in gentrifying urban centres across North America, with the scope of the social and health inequalities that are ultimately produced often dependent on the local context (Wacquant, 2012). Through this lens, not only are gentrification-induced inequalities being produced uniquely in Ottawa as a whole, but the oppressive impacts of gentrification can also differ within the city’s various neighbourhoods. To achieve health equality for vulnerable populations from a service delivery perspective, then, an understanding of the interaction of neoliberalism and gentrification within neighbourhoods is critical.

According to a 2009 report from the Institute for Children and Poverty, a rapid rise in average household income in any given community is one of the primary indicators of the beginning stages of gentrification: “As a neighbourhood undergoes a period of reinvestment and revitalization, higher-income households are attracted to the area” (p.2). In each of the geographic areas where the CHCs of research participants are located, census data indicates that a noticeable shift in the number – and value – of owned dwellings occurred between 2001 and 2006, signalling tangible socio-economic change (Statistics Canada, 2011). While the residential dwellings of these traditionally mixed-use, urban neighbourhoods largely consisted of rental properties in the past; the number of rented dwellings remained mainly flat between 1996-2006. Meanwhile, the number of owned dwellings made a significant jump between 2001-2006 and 2006-2011, following noticeable spikes in median family income<sup>4</sup>. With a rise in household income comes not only increasing housing values, but rapidly rising rental prices as well, as “landlords encounter

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<sup>4</sup> Numbers recorded for 2011 versus those recorded between 1996-2006 can only be used as relative indicators of demographic change(s) versus absolute indicators. While Canada’s long-form census was mandatory prior to 2006, the 2011 National Household Survey (NHS) was voluntary, and acknowledged that large discrepancies in data may exist; particularly in smaller communities. In reference to the data in the tables that follow, the actual numbers of owned/rented dwellings, for instance, may be larger, while the average value of owned dwellings may be lesser or greater.

new residents who are willing to pay a higher market rate for housing than current residents” (ICP, 2009, p.2). Increased educational attainment of the population is another early sign that gentrification is occurring.

While the tables below show a modestly growing population in urban Ottawa neighbourhoods between 2006-2011, they do not account for the replacement of certain marginalized populations by more affluent newcomers. In each area, the number of rental dwellings has remained relatively stagnant between 2001-2011, while the median income, education level and number/value of owned dwellings have grown significantly. Between 2001-2011, the number of owned dwellings in Centretown grew by 40 percent, while the number of rented dwellings grew by only six percent. This correlates with the observable transformation of the built environment in each neighbourhood, where condominiums and commercial redevelopment projects have become predominant features of these formerly mixed-use spaces. With the growth of rented dwellings failing to keep up with that of owned dwellings over a 10-year period in Centretown, the neighbourhood’s population increase of just 12 percent during that timeframe does not merely indicate growth, but rather, the replacement of lower-income residents with more economically privileged ones.

***Table 1: Key population and housing data for census tract 0038.00 (Geographical region in which Centretown Community Health Centre is located; Centretown)***

Variable	1996	2001	2006	2011
Population	3,776	4,199 (11.2% increase)	4,482 (6.7% increase)	4,740 (5.8% increase)
Number of owned dwellings	105	170 (61.9% increase)	465 (173.5% increase)	590 (26.9% increase)
Number of rented dwellings	2,285	2,480 (8.5% increase)	2,415 (2.6% decrease)	2,635 (9.11% increase*)
Average value of owned dwelling	\$161,958	\$205,137 (26.7% increase)	\$363,255 (77% increase)	\$459,618 (26.5% increase)
Median income (All census families)	\$23,583	\$39,252 (66.4% increase)	\$40,559 (3% increase)	\$73,605 (81.5%)
University – population with bachelor’s degree or	875	1,270 (45.1% increase)	1,570 (23.6% increase)	2,150 (36.9% increase)

higher				
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Source: Statistics Canada (1996, 2001, 2006); NHS (2011)<sup>5</sup>

**Table 2: Key population and housing data for census tract 0053.00 (Geographical region in which Sandy Hill Community Health Centre is located; Sandy Hill)**

Variable	1996	2001	2006	2011
Population	2,726	3,041 (11.6% increase)	3,220 (5.9% increase)	3,265 (1.4% increase)
Number of owned dwellings	70	135 (92.9% increase)	295 (118.5% increase)	510 (72.9% increase)
Number of rented dwellings	1,505	1,740 (15% increase)	1,700 (2.3% decrease)	1,655 (2.7% decrease)
Average value of owned dwelling	\$190,534	\$176,284 (7.5% decrease)	\$257,706 (46.2% increase)	\$351,764 (36.5% increase)
Median income (All census families)	\$36,387	\$41,734 (14.7% increase)	\$40,227 (3.61% decrease)	\$61,013 (51.7% increase)
University – population with bachelor’s degree or higher	535	895 (67.3% increase)	1,015 (13.4% increase)	1,395 (37.4% increase)

Source: Statistics Canada (1996, 2001, 2006)

Some social service workers based in the gentrifying Ottawa neighbourhoods under study say that the rising cost of rent and changing neighbourhood demographics have had a negative impact on some of their lower-income clients. Steve, a harm reduction outreach worker, and Jennifer, a

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<sup>5</sup> What these tables do not explicitly state is the *type* of rented dwellings that exist in this neighbourhood. Prior to the condo boom that peaked around 2006, rented dwellings in Centretown largely comprised of apartments. By 2011, however, it appears that many condominium units had been built and purchased, and were being rented out by independent landlords at much higher prices than older rental units. The same year (2006) that the number of owned dwellings increased 173% and the number of rented dwellings decreased 2.6%, the median income of the population only increased 3%. By 2011, however, by the time the number of rental units took an upward turn (9% increase), the median income of the population had also increased by 81.5%. Given the very modest increase in the neighbourhood population, these numbers indicates a different, more privileged type of renter moving into the area.



nurse practitioner, are based out of the same CHC, and work closely with illicit substance users and rooming house clients. They both say that the socio-spatial transformations occurring in the area around their CHC have led to the displacement of a number of vulnerably housed people:

I remember when I moved here [five years ago], people were able to find places for like, \$400. Now, rooming houses that are like, three metres by three metres – without your own washroom or your own sink or anything – are going for like, \$600. So that's had a dramatic impact...you see a lot of people moving further outside the periphery (Steve, harm reduction worker).

Jennifer first observed a noticeable shift in the demographics served by her CHC beginning in 2008; around the same time that gentrification started to reach its peak in the surrounding neighbourhood. Through her work with her CHC's harm reduction outreach van, for instance, she said she began to notice that the populations of sex workers she had previously served were becoming fewer. As gentrification of the neighbourhood around her CHC continued, she said she also noticed a significant change in the types of people who were coming to the centre's brick and mortar location to access social and health services: "Between 2008 and 2010, it was just like, suddenly, everyone and their dog...young families were [moving in]. And all of a sudden, they were who we were seeing in our walk-in clinic". Between her centre's walk-in becoming busier, and the demographics of people using the walk-in becoming observably more homogenous and middle class, Jennifer said that accessibility to primary health and social services has become challenging for more vulnerable clients:

Our walk-in is first come, first serve, and the traditional people that we were helping...they're not great at waiting [...] and so I feel when people are made to wait who aren't good waiters, then we end up not seeing them as much, you know?

Steve and Jennifer's narratives illustrate a pattern of gentrification-induced displacement at its most basic level: The cost of rent/lodging rises, families and young professionals move in, and vulnerable populations begin to disappear from public (and private) spaces. Gentrification-induced displacement refers to the involuntary movement in terms of address (both fixed and non-fixed address) of neighbourhood residents, including those who are homeless and/or in transition (Martin, 2007; DeVerteuil, 2011). Hartman (1984) describes this oppressive process as "changes of residence which are hoisted on people, which they did not seek out on purpose, for which they

may lack the social and economic coping resources” (p. 302). In almost all cases, displacement signals systemic class-based or race/culture-based discourses and practices of socio-spatial exclusion within a respective neighbourhood, where “replacement of one group by another in a relatively bounded geographic area, in terms of prestige and power [occurs]” (Martin, 2007, p. 604). Often, the impact of being displaced from the inner city into cheaper or less central neighbourhoods means a detrimental ripple effect, where populations that are already marginalized in terms of social class, race, ability, age and/or sexuality can experience increased oppression due to cuts in community ties, decreased mobility options and difficulty accessing health and social services (Betancur, 2011; DeVerteuil, 2011; Mazer & Rankin, 2011; Newman & Wyly, 2006).

From a social justice-oriented perspective, Hackworth (2007) argues that the infiltration of gentrification projects into previously mixed-use, urban neighbourhoods indicates symbolic oppression of the incumbent population that goes far beyond the physical renovation of space: “[Gentrification] marks the replacement of the publicly regulated Keynesian inner city...with privately regulated neoliberalized spaces of exclusion” (p.120 – 121). While the neoliberal redevelopment policies and projects being spearheaded by the City of Ottawa function to create new, homogenous urban frontiers, neoconservative discourses related to punishment and exclusion ensure that these growing spaces of privilege remain undisrupted and uncontested.

To illustrate the growing spaces of exclusion in gentrifying Ottawa neighbourhoods, Steve recounts one example where many of his CHC’s former clients were forcibly and systemically displaced from their homes due to their marginalized statuses as new immigrants – and *not* because they couldn’t afford to pay their rent. In 2011, the owners of one aging high-rise building in the neighbourhood (which had traditionally been home to low-income, immigrant families and students) began major renovations to the building’s suites. After they sold the property to a real estate investment trust in 2013 (OBJ, 2013), Steve said that he found out through a colleague that many tenants had been “illegally evicted” in the process:

Apparently this landlord targeted specifically, English as a second language-sounding names, and was like “you have to sign this” [notice]. Because normally, even despite the renos and the expansion, people are entitled to move back at the same rates, right? But people didn’t know this, so I think they got like, half the tenants out that way. So it was really dirty – and by the time we caught wind of it...like, I tried to have protective housing help, but it was all too late.

In this case, said Steve, previous residents of this high-rise apartment likely misunderstood – or were unaware of – what their rights as tenants were. According to section 56(1) of Ontario’s Tenant Protection Act, a tenant who receives notice of termination of a tenancy for the purpose of repairs or renovations has the right of first refusal to re-occupy the rental unit as a tenant, once those renovations have been completed. Although the rental prices of these units are now well above the Ottawa average of \$1,201 (2-bedroom apartment) (CMHC, 2017), with monthly rent ranging from \$1400 for a 1-bedroom to \$2800 for a 2-bedroom and den (CLV Group, 2015), the former residents of the unit should have legally been given the option to stay. Steve’s telling of the unjust way in which the evictions of more vulnerable tenants occurred, however, indicates that the new building owners were looking not only to collect higher monthly rents, but to fill units with a more homogenous type of tenant.

Though the reinvestment of urban capital that business, residential and commercial redevelopment brings to downtown neighbourhoods is consistently being touted as positive by the City of Ottawa through its municipal policies and public discourses (City of Ottawa, 2009), the gentrification-induced displacement that occurs can mean significant oppression and marginalization for those who are no longer welcome within new, more exclusive built environments. While displacement and disenfranchisement may often appear to simply be unfortunate symptoms of gentrification, the above example shared by Steve demonstrates how the replacement of vulnerable populations with more privileged ones is, in fact, a deliberate, political project.

### **New-build gentrification and indirect displacement**

While Glass (1964) originally conceptualized gentrification simply as the construction of new residential and commercial buildings on previously developed lands, more recent scholarship also considers redevelopment on infill or brownfield sites as part of the continuum. Davidson and Lees (2004, 2010) argue that this type of “third-generation gentrification” does cause displacement and subsequent marginalization of incumbent neighbourhood residents, despite the frequent claim from developers and municipal governments that displacement cannot occur through infill projects that expand the neighbourhood’s housing stock (CBC News, 2012; Urban Capital, n.d.). Although it is true that new builds do not always correlate with the tear-down of older homes or

high-rises, Davidson and Lees (2004, 2010) assert that these processes lend themselves to the creation of a “gentrified landscape”, which can compound oppression for neighbourhood residents who are vulnerable and/or vulnerably housed or homeless.

Although Urban Capital’s 2012 condominium project at Bank Street and Gladstone Avenue in Centretown (discussed in Chapter 1), for instance, did not *directly* physically displace residents from their homes (in this case, a three-phase mixed commercial and residential development replaced a surface parking lot and a church), it instead posed the risk of *indirect* displacement of residents through increasing rental prices and the creation of exclusionary public spaces (Davidson and Lees, 2004; Lopez-Morales, 2015). Through indirect displacement, political displacement and marginalization also exist as potential, longer-term impacts for residents under siege, who are at risk of becoming disfranchised and less involved in their communities when they no longer feel as though they “belong” (Martin, 2007, p. 605).

Under third-wave gentrification, displacement is much more nuanced than a direct result of rent hikes or evictions of lower-income neighbourhood residents. Davidson and Lees (2010) write that it is problematic that displacement has been traditionally and regularly “conceived of as a singular outcome, [and] not as a complex set of (place-based) processes that are spatially and temporally variable” (p. 400). Beyond the negative impact felt by those physically displaced, both traditional and new-build gentrification can also result in a sort of “dispossession” of the neighbourhood for those who remain rooted in place – where spatial transformation can mean social limitations for neighbourhood residents who are disproportionately low income, working class/poor, elderly, or of racialized groups (Marcuse 1985). Within this “economic polarization of the population,” says Marcuse (1985), “a vicious circle is created in which the poor are continuously under pressure of displacement and the wealthy continuously seek to wall themselves within gentrified neighbourhoods” (p. 196). In short, argue Davidson and Lees (2004, 2010), by intending to quickly introduce large, new demographics of middle-income residents into communities, the third wave gentrification that is responsible for indirect displacement has become a decidedly political project, with new-build gentrification having become “even more closely intertwined with government interventionism [and] sold through policy discourses about ‘mixed communities’” (Davidson & Lees, 2010, p. 397).

Gentrification-induced displacement and dispossession are critical concerns from a social justice-oriented perspective, as neoliberal redevelopment projects continue to rapidly infiltrate the

urban landscape, indicating “the deepening class polarization of urban housing markets” (Newman & Wyly, 2006, p. 23). Not only is the negative impact of gentrification on vulnerable populations a social justice issue in terms of cause and effect, but it is also a symptom of the larger, systemic inequalities and oppressive power dynamics reflected through small-n neoliberalism (Wacquant, 2012). Through its interaction with overarching neoliberal discourses, gentrification highlights “the significance of socio-political patterns and the particularities of time and space” (Hankivsky et al., 2011, p. 13), and reveals how those citizens who were previously experiencing different types of social and economic marginalization are most susceptible to displacement. In general, those vulnerable populations who stand to experience the most oppression as a result of neighbourhood gentrification tend to be “from those parts of the population who were already marginalized because of their socio-economic status, their ethnic or racial identities, gender, or some combination of these characteristics and identities” (Rosenberg, 2014, p. 466 – 67).

As urban neighbourhoods continue to undergo gentrification, the displacement of vulnerable populations serves not only to immediately oppress those who are directly – or indirectly – removed from their neighbourhoods, but it also leads to the creation of a privileged, homogenous landscape that is inaccessible to marginalized groups. According to Newman and Wyly (2006), “the impact of the restructuring of urban space [hampers] the ability of low-income residents to move into neighbourhoods that once provided ample supplies of affordable living arrangements” (p.26). The oppressive restructuring of urban space is an ongoing process in Ottawa. In its 2016 progress report, for instance, the Alliance to End Homelessness Ottawa revealed that the increasing lack of affordable housing in the city had rendered more families homeless than ever, with a total of 879 families accessing emergency shelters (a 12.5% increase from 2015, and a 24.5% increase from 2014). The year 2016 also reflected an increase in the number of single men and single women accessing shelters, and a significant rise in the number of older women and the number of youth residing in shelters for longer periods of time (from 2015 to 2016, shelters in Ottawa saw a 20.1% increase in the number of women over 50 and a 31.2% increase among those over 60. Meanwhile, the average length of stay for youth increased from 32 to 47 nights). While 320 new affordable housing options were created in 2016, the year 2015 reflected the lowest number of new, affordable housing units in a decade, which inevitably has played a role in the growing housing precarity of the city’s aging and youth populations.

In addition to the obvious lack of affordable housing in the city, housing case manager Chris says that growing systemic exclusion within the existing rental market has had a significant impact on the clients he works with:

For us, one of the big barriers [to service delivery] is housing. There's not a lot of choice in Ottawa when it comes to housing. Ottawa has a historically, very low vacancy rate. So that creates problems, because the market can be choosier – so when it comes to our clients, they can exclude them easier. Then what happens is that landlords who *do* take our clients end up usually being in very specific neighbourhoods – even in very specific parts of neighbourhoods.

In this example, Chris demonstrates layers of oppression that exist for homeless populations beyond the city's lack of affordable housing. Here, the social exclusion demonstrated by landlords towards vulnerably housed individuals indicates that even if available affordable housing stock exists, this housing can often be inaccessible due to the city's increasingly neoliberal and homogenous urban landscape.

Through his work, Chris said that he has become aware that a growing number of landlords in the city are becoming involved in the Ottawa Police Service's *Crime Free Multi-Housing Program*, an initiative which is “designed to help owners, managers, residents and police work together to keep illegal and nuisance activity out of rental communities” (Ottawa Police Service, 2015). According to the program guidelines, the policing and prohibition of certain tenants and/or prospective tenants occurs through tactics such as police audits of a property's building and grounds, and the training of landlords in understanding things like “crime prevention”, “resident selection” and “combating illegal activity”. It is neoconservative programs such as this that appear to be interacting with the city's neoliberal housing market to create significant barriers for some of Chris' vulnerable clients:

Apartment buildings are now asking for police checks before you can live there. So, if you have a record, they can exclude you. So that's one thing that's causing *huge* problems, because that means our clients can't go there.

Jennifer, who works largely with rooming house clients in a different urban neighbourhood, said that she has been hearing similar narratives from her vulnerably housed clients about landlords applying exclusionary criteria when selecting tenants:

When you rent a place, they can ask you for your criminal record, they can ask for references...and that's where people are being ousted, I find. They want to meet you, they take one look at [...] the tattoo on your face, and you're done. And that's the part that I find is really difficult for the people, too. It's not so much the rent amount, as now, the landlords are in charge, and they can be pickier. And it really makes it so difficult for people.

The institutionalized marginalization of clients who may look or act a certain way makes finding stable housing an increasingly difficult feat. Even if vulnerable populations have the financial means to rent, this “exclusionary displacement” (Davidson and Lees, 2004) makes certain properties inaccessible to those marginalized populations who do not fit into the vision for the new, homogenous urban landscape. With demand for downtown residential units continuing to grow amongst the affluent as urban redevelopment intensifies, power appears to have shifted to landlords, who are carrying out neoliberal discourses through their push to fill rental units with a more “desirable” type of resident. Meanwhile, vulnerable populations who can no longer access urban housing due to unaffordability and/or exclusion become at risk of increased marginalization, as they are displaced from the downtown neighbourhoods that continue to house important social and health services.

### **The importance of proximity to services**

Whether they find themselves physically removed or socially disenfranchised from the neighbourhoods they once called home, some of the most significant impacts of gentrification-based displacement for vulnerable populations are the new physical and social barriers that effectively put important health and social services out of reasonable reach. A number of studies on socio-spatial barriers argue that spatial proximity to social services is paramount for vulnerable populations, and that increased distance from a provider significantly reduces accessibility and utilization (DeVerteuil, 2011, Nemet & Bailey, 2000; Allard et al., 2003). Many of these citizens, for instance, “have limited mobility and would find it difficult to access a more dispersed service configuration” (DeVerteuil, 2011). Allard et al.'s (2003) study on vulnerable populations who access welfare services in a particular community in Detroit, Michigan, for instance, concluded that individuals faced increased barriers in terms of service accessibility once they no longer physically occupied that geographical area, and that “the spatial accessibility of service providers is an important determinant of service utilization” (p. 610). As gentrification often results in the

displacement of those members of the community already facing the most oppression and marginalization (those who disproportionately require access to critical community-based health and social services), spatial accessibility and proximity to services (or lack thereof) becomes yet another process of oppression that has the potential to produce inequitable health outcomes.

In Ottawa – as in the majority of urban centres across Canada – critical health and social services tailored towards society’s most vulnerable populations have traditionally been located within the inner city. For those with mobility issues (either physical, economic and/or social), the proximity to social services that centrally located CHCs offer is paramount, and the risk of gentrification-induced displacement has the potential to result in inequitable health outcomes for neighbourhood residents most susceptible to resettlement. While residents in Ottawa’s centrally located Centretown neighbourhood, for instance, are on average just 0.3 kilometres away from a physician at any given time, the Ottawa average in terms of proximity is almost 10 times as far. Mental health services are also much more accessible to Centretown residents, along with resources like youth services, Aboriginal centres and harm reduction services (Ottawa Neighbourhood Study, 2016). As the table below demonstrates, vulnerable populations who become displaced from neighbourhoods where they were once in very close proximity to services could face major barriers to accessing care if their average distance to a CHC, for example, increases by 700 percent. Not only could displacement to the suburbs mean significant mobility barriers for those requiring access to health, social and cultural services, but loss of entitlement to services altogether.

***Table 4: Proximity to and availability of social services and other resources in wider neighbourhoods under study***

<b>Variable</b>	<b>Centretown</b>	<b>West Centretown</b>	<b>Sandy Hill</b>	<b>Ottawa Average</b>
Average distance to nearest CHRC (km)	0.8	0.8	0.9	7
Average distance to a pharmacy (km)	0.3	0.5	0.5	1.7
Average distance to a mental health service location (km)	0.9	0.9	1.5	9.6



Average distance to nearest Aboriginal resource centre (km)	0.5	1.1	0.7	12.6
Average distance to nearest employment service (km)	0.3	0.5	1.3	6
Average distance to nearest immigrant service (km)	0.4	0.6	0.9	6.6
Average distance to nearest library (km)	1	1.8	1	3.6
Average distance to nearest physician (km)	0.3	0.3	0.5	2.8
Average distance to nearest food bank (km)	0.7	1.1	0.8	6
Number of needle drop boxes	3	5	1	0.5
Number of youth services	14	7	1	0.8
Number of social and affordable housing units	2,624	1,471	1,070	229.4
Number of rooming houses	32	23	43	1.4

*Source: Ottawa Neighbourhood Study (2016)*

When clients of CHCs and other community-based social services undergo gentrification-induced displacement, accessing services can become *actually* restricted, as CHCs generally have geographic boundaries. This means that once vulnerable populations are displaced from neighbourhoods, they technically no longer qualify to continue to receive services from the area's associated CHC. "I have a number of clients that I don't see anymore, because they've moved to different locations," said Jennifer. In many cases, displacement not only means inaccessibility to particular health professionals or services, but inaccessibility to community-based care altogether,

as the populations who require these services the *most* are often relocated to more suburban neighbourhoods with the poorest access. Steve, who works closely with many vulnerably housed and homeless clients with substance abuse problems, said that the city's shrinking stock of affordable housing combined with the growing neoliberal barriers to accessibility of centrally-located rental units is having a direct impact on his centre's ability to house vulnerable populations in the area. This, he believes, is affecting former clients' ability to access social services:

We're trying to house people who already have such huge barriers to housing, whether it's because of mental health [issues], because of income, because of criminal record, because of history of drug use [...]. It got harder and harder to the point where it's like, now the only affordable apartments are outside of the community. So you definitely see people migrating further out, closer to Merivale – which is far, right? And this is where they relied on for, you know...soup kitchens or food banks. There, it's actually kind of a deadzone.

According to Skinner and Masuda (2013), achieving health and social equity for vulnerable populations within cities is “contingent on [their] ability to move within and around the city (physical mobility) in order to participate in the full range of urban resources and opportunities (social mobility)” (p.212). Their 2013 study on the relationship between urban space and health inequity amongst Aboriginal youth in Winnipeg, Manitoba argued that sense of place within one's city or neighbourhood is closely linked to one's overall health outcomes. The study concluded “physical and social threats produced within urban space (and that produce urban space) have significant and multi-faceted impacts on health” (Skinner & Masuda, 2013, p.217). When physical and social threats introduced by gentrification displaces citizens, or limits their ability to move around within their neighbourhoods, the overall health of individuals stands to suffer.

One example of the types of threats that gentrification is posing in downtown Ottawa neighbourhoods can be illustrated through Rob's account of how condominium redevelopment projects in the area around his CHC's neighbourhood have impeded clients' access to certain services:

When we had the construction happening on Rideau Street [down the street from the centre]...first of all, they put a big fence up – so it was actually really hard just to cross the street – but the other thing is that while the construction was happening, there was always a marked police car there as well [...]. We saw our numbers go down then, and we saw a big drop in needles in the [Byward] Market area, between us and [Ottawa] Public Health. What

was explained to us at that time when we asked the community, is that the people didn't want to be coming into our service – they were actually going and buying needles at the drugstores...they felt it was a little too hot here to pick up stuff.

Here, Rob highlights how some of his clients who have managed to remain rooted in their neighbourhoods despite processes of gentrification, are still at risk of having their health outcomes impacted. In this example, the physical barriers enacted through gentrification interact with neoliberal/neoconservative discourses related to surveillance and perceived punishment to produce a restrictive and exclusionary geographical environment. While they may still live in a neighbourhood that has a CHC, the perceived inability to move around (and the subsequent withdrawal from social service programs) can have a negative and multi-faceted impact on the health of a centre's most vulnerable clients. Though downtown neighbourhoods are still currently home to the most social services per capita (in comparison to the Ottawa average), it is unclear how both temporary and permanent barriers to accessibility brought on by gentrification may have a long-term impact on certain marginalized individuals' accessibility to services, and ultimate health outcomes.

At the same time that restrictive barriers to services are appearing around CHCs, one frontline social service worker said that disappearing neighbourhood resources and establishments geared towards lower-income populations (i.e. Laundromats and pawn shops) are simultaneously contributing to the marginalization of her clients:

The Laundromat is gone, and now the wellness shop is in there, so there's nowhere to do laundry on Bank Street anymore...low-income places are starting to go. We're not going anywhere – [our CHC is] not moving away, so clients are still going to be coming – at least I would hope so – but if there's nothing else for them here, or if there's such a high risk of being criminalized or policed because people are calling frequently – because they don't like the sight of them – there's a *huge* implication for that. So it is a pivotal time, because those...are small examples of how [neighbourhood change] is starting to happen (Erica, frontline social services worker).

As physical barriers like the ones Rob illustrated above make downtown streets more difficult to navigate for some, Erica believes that the diminishing sense of place that comes from the simultaneous disappearance of businesses and resources largely frequented by vulnerable populations is also causing her clients to withdraw from public spaces.

Jennifer has also observed that the loss of certain businesses in the neighbourhood around her respective CHC has had an impact on her clients. After a nearby grocery store closed, for instance, she said she noticed a slight demographic shift of clients within her centre:

I know why [the store] closed....they really had a hard time. But it's too bad, because that changed the dynamics of our neighbourhood a little bit. We used to get a lot of people – just traffic coming in, [where clients would] go to the grocery store, and then they'd come by and see us and...it was sort of one-stop shopping. And now, food is a real issue in our neighbourhood for people who don't have a lot of mobility.

Although many vulnerable populations continue to reside in neighbourhoods undergoing socio-spatial transformation, numerous businesses or services that previously catered to low-income residents no longer exist, and are instead, being replaced by more expensive shops or condominium projects. Another example of this is the disappearance of the former Laundromat at the corner of Bank and James Street in Centretown. The Laundromat used to serve not only as a place for those in nearby apartment buildings to do their washing, but also doubled as a space where regular customers would talk with their neighbours, and where homeless people could warm up in the winter. Now, a high-end “herbal apothecary” stands in this formerly community-oriented space. The examples above demonstrate how the impact of gentrification is multi-faceted, and can produce diverse oppressions, depending on the socio-spatial context. While residential displacement can inevitably create accessibility issues for vulnerable populations who require access to critical health and social services, the displacement of certain businesses can also lead to the withdrawal of vulnerable populations from public spaces.

### **A sense of place and public space**

For incumbent residents of gentrifying neighbourhoods, residential and commercial changes do not merely change the physical space of the area, but the social production of space as well. According to Lefebvre (1991), *spaces of representation* are produced through the interaction of the physical environment with the social practices and systems of knowledge in a particular, geographic area. Moreover, a *sense of place* refers to “the perceptions residents have of their own environments, encompassing social and structural features” (Williams & Kitchen, 2012, p.258). According to Murphy et al. (2008), this sense of place (generally linked to attachment, familiarity

and identity) can become significantly disrupted through gentrification-induced displacement, disorientation and alienation, and can lead to negative psychological, physical, economic and social effects (p.67). While the disappearance of certain businesses and services in gentrifying Ottawa neighbourhoods *tangibly* puts important, everyday resources out of reach for many vulnerable populations, the appearance of new commercial and retail tenants also contributes negatively to how some residents may be navigating and understanding their respective changing neighbourhood spaces:

Certain business have come up that contribute to people not feeling comfortable...people look at them like they don't belong there. I do remember someone once...really talking about this sense of displacement, and almost being made to feel like a refugee in the community that is yours. They talked about how they can't afford to go into any of these new places that have popped up. (Steve, harm reduction outreach worker)

While direct, gentrification-induced displacement works to physically remove residents from particular spaces, the *indirect* displacement associated more closely with self-displacement and loss of “right to the city” (Lefebvre, 1968) can have a negative impact on one’s sense of place. Belanger’s (2012) study of the existing tensions between new and incumbent residents in a gentrifying Montreal neighbourhood demonstrates this. As a result of neighbourhood revitalization and processes of gentrification, many residents who had previously spent time in nearby Lachine Canal Park said they had begun experiencing feelings of “invasion”. While increased pressure on housing markets and potential residential evictions can result in displacement, participants in Belanger’s (2012) study express that even public areas such as streets or parks – which arguably have no market value – are being increasingly co-opted by area gentrifiers.

Though public spaces may have never been without the intersection of politically and socially oppressive forces, Belanger (2012) argues, public spaces today “are facing dynamics of exclusion of the ‘undesirables’” (p.33), as neoliberal governments increasingly place importance on revitalizing, commercializing and profiting from the creation of a certain image of the gentrified city:

Efforts made to sanitize/homogenize public spaces through design, programmed uses, activities and exclusion (or harassment) of more marginal populations are the manifestation of an attempt to satisfy the tourists, investors, workers, and to show consideration to their ‘sensibilities’ (Belanger, 2012, p. 34).

This strategy to “sell” the city to certain privileged demographics extends to approaches at the neighbourhood level, too, adds Belanger (2012). These approaches are often reflected in the creation or revitalization of parks or other public spaces, as an attempt to appeal to the influx of middle- or upper class residents who are moving in. As mentioned in Chapter 1, for instance, Urban Capital Property Group’s (failed) marketing efforts to “re-brand” the neighbourhood of Centretown as “South Central Ottawa” in 2012 can be interpreted as a direct attempt by developers to erase Centretown and all that it previously stood for in the public consciousness. Since the mention of a neighbourhood name brings with it a particular sense of place, eradicating and replacing the name of this mixed-use neighbourhood would signal to certain vulnerable populations that the area was no longer a place where they were welcome.

Belanger’s (2012) discussion around the homogenization of public spaces through gentrification can also be reflected through the controversy around Ottawa’s Dundonald Park. Located in Centretown, this public space has long been the site of much contention (and tension) between privileged and marginalized neighbourhood residents. The park, which occupies one urban city block, is located across the street from a long-standing Beer Store retail outlet, and has, in the past, been a regularly frequented spot by illicit substance-using populations. The space has been referred to (among other things) as “crime-ridden” (Turcotte, 2013) and is seen as being frequented by people who behave in ways that are “not good for the children watching” (CBC, 2012). The Beer Store location closed for renovations for almost two years between 2013 and 2015 (Centretown Buzz, 2015), and around the time it was slated to open in its renovated form, Erica said there was significant pushback from some members of the community, who approached a local city councillor with concerns that if the store reopened, there would be an influx of “undesirable” populations returning to the park:

Hearsay is that some of the folks who were frequenting the park to use [drugs and/or alcohol] apparently weren’t doing it so as much or as often [while the Beer Store was closed for renovations]...there weren’t as many “problems” according to a very small pool of surrounding neighbours and residents. The concern was that [once the store re-opened] there will be problems; that it would regress all the “progress” that’s happened in the park...that there will be people who are violent who will access that space as a result.

Following these complaints, Erica said that her centre was invited to meet with Ottawa Police, Ottawa Bylaw, Beer Store management, and some of the disgruntled neighbourhood residents. Although they were the topic of conversation at the meeting, said Erica, none of the vulnerable populations who frequented the park were invited to participate in the discussion. As a result of this lack of representation, Erica decided to partner with colleagues at a nearby CHC, and hold focus groups in the summer of 2015 with several of the marginalized individuals whom residents were trying to remove from the public park. What resulted from these focus groups was a one-page information sheet for community members, along with an informal report containing recommendations and perspectives from vulnerable individuals who place great importance on their ability to access public space such as Dundonald Park. Some of the reasons listed by participating individuals for why they are dependent on access the park included: (1) because they often have nowhere else to go, as there is a long (approximately 7 years) waiting list for housing, and no safe consumption site in Ottawa; (2) because they feel safe, as there are other people around, and there is good visibility; and (3) because they feel a sense of belonging, as they see their friends there regularly and they consider it to be their neighbourhood park. The information sheet also outlines alternative, supportive resources that neighbourhood residents can access apart from police, if they “have a concern that does not threaten someone’s life”, including phone numbers for the Salvation Army outreach van and the STORM van (serves Indigenous women); information about joining the Dundonald Park working group; and tips on advocating to government representatives for more funding to be allocated to outreach and support services. The report reads:

Living in an urban centre nearby mental health, addiction and homeless service providers on Bank St. means that incidents are to be expected. Involving police, bylaw, or Neighbourhood Watches, does not create supportive outcomes for the entire community.

With the neighbourhood around her CHC becoming increasingly gentrified, Erica said that she has not only noticed increased police presence around Dundonald Park, but in the wider area in general:

With any gentrification, there’s always been correlation of increased police [...] the emphasis is on clean-up; clean-up; clean-up. So as this neighbourhood continues to gentrify...it will probably get a lot worse, which scares me, because in the last year, it’s been pretty bad.

With ongoing neoliberal redevelopment projects effectively displacing residents from their homes and diminishing their accessibility to resources, public spaces like parks become increasingly important for vulnerable populations who are seeking out a sense of community. At the same time however, neoconservative discourses around punishment of bodies that are “disruptive” to the new urban landscape are making public spaces increasingly hostile and unsafe for those whose livelihoods often depend on access to these spaces.

Though Erica and a few of her colleagues have been working to bring the voices of drug-using populations who frequent Dundonald Park into conversations related to resource planning within her own CHC, she said that she has observed a recent, concerted push by her centre to shift some programming to appeal to a new, more privileged kind of client. In the last three to five years, for instance, said Erica, her CHC has “really engaged” the park, and has begun holding regular activities there, targeted at the local community. The impact of this, said Erica, has been detrimental for her CHC’s more marginalized clients:

When you’re inviting people to come to the park, you’re also setting things up so that exclusion of folks who are already going there – and are comfortable going there – happens. So even though the intention is good; the intention is to be inclusive...inevitably, when you invite someone in, someone else gets pushed out. [The organized activities are] mainstream focused – meaning anyone can come, but like...who’s going to come do hula hooping and physical activity on Tuesday morning? There’s a certain population that’s more attracted to that.

Here, Erica gives an example of how her centre may be playing a role in disrupting the sense of place and space that certain vulnerable populations associate with Dundonald Park. Though her CHC is aiming to “engage” park-goers in a positive way, Erica believes that the type of activities and resources that her centre is offering in this environment caters towards a very homogenous type of population. In this scenario, overarching neoconservative discourses manifest through increased police presence and surveillance to displace “undeserving” populations from the park and create a more sanitized and privatized space. Meanwhile, activities put on by Erica’s CHC that are geared towards more homogenous populations serve to attract new, more “deserving” populations to the park; effectively disenfranchising the vulnerable individuals that remain.

While commercial and residential redevelopment play a significant role in transforming urban landscapes, the above examples show how feelings of disenfranchisement within a



gentrifying environment can be so overwhelming that even public spaces that have remained untouched by redevelopment projects can become increasingly hostile and exclusive. As the socio-economic demographics of downtown Ottawa neighbourhoods continue to shift, then, these examples show how the replacement of incumbent marginalized populations with more affluent gentrifiers is not a “natural” process or effect. Instead, these oppressive processes are a result of neoliberal and neoconservative discourses carried out determinedly by neighbourhood players who systematically work to govern and privatize public spaces.

### **Displaced communities of care**

Within gentrifying neighbourhoods, intersecting oppressions are functioning to displace not only communities of vulnerable populations, but communities of social service organizations, as well. While Chapter 2 discussed how neoliberal funding cuts have limited the scope of delivery for certain community-based services like Centre 507 (from a resource perspective), the following example shows how communities of social service providers are also disappearing from gentrifying neighbourhoods due to dynamics of exclusion (Belanger, 2012).

In May 2013, the Aids Committee of Ottawa (ACO) signed a lease for a new office space at 240 Bank Street. The ACO, which had formerly been located just a block away at 251 Bank Street, had long been a staple of the social services landscape in Centretown, alongside community health centres, drop-in programs for homeless populations, women’s shelters, youth services, multicultural services and more. When it came time for the ACO to take possession of the space on October 1, 2013, however, the landlord allegedly terminated the agreement. The ACO, which had planned to establish a harm reduction drop-in program (including safe injection and safe inhalation supplies) among other resources for its clients, launched a small claims lawsuit, accusing the landlord and real estate agency of discrimination; citing \$35,000 in damages. In its lawsuit, the ACO alleges that the landlord “had expressed concerns that people who visited their centre would spread lice and have to share hallways with other visitors or tenants and would present security concerns in the stairwells” (Seymour, 2014).

Erica, who works in the neighbourhood that the ACO formerly occupied, expressed her concerns around this incident:

This is a really good example that shows [...] implications, obviously, for the folks who are accessing the services, but then also for the services themselves [...] how the discrimination seeps over into the actual agency as well.

In the case of the ACO, neoliberal discourses have interacted with the surrounding, gentrifying neighbourhood, to displace an organization from a neighbourhood that it had been implanted in for years, despite the fact that it could afford to remain in the area. Not only was the displacement of the ACO detrimental to its particular clients, but it also had a negative impact on the wider, overall landscape of social service delivery within the area. According to Erica, the displacement of the ACO had direct health repercussions for her centre's clients:

For harm reduction, I think the amount of supplies taken was almost 90,000 last year – so it increases a lot every year, and we only have a part-time harm reduction worker. So, ACO was right across the street, and it was great because they would [share supplies]. So now that's lost.

In addition to the loss of the ACO's resources through exclusionary practices, the rising cost of rent associated with gentrification is also having a significant impact on the smaller, grassroots service organizations in the area, according to Erica. This situation, she said, is indirectly impacting the capacity of her centre to deliver services, by threatening the existing network of integrated, community-based service provision:

We're really well funded, but places like Operation Come Home and Centre 507 [nearby, grassroots service delivery organizations] are talking about moving, and they've been talking about that for a little while now, because they just got a lot of [their] funding cut.... [and] when we hear that, we get panicked. Not just because it's a resource for the folks, but it's a really important resource for *us*, to be able to send people [to different centres] that we do partnership stuff with.

According to DeVerteuil (2012), the persistence of social service hubs in the gentrified inner city “guarantees the continued existence of the public city” (p.214). However, as neoliberal and neoconservative discourses around privatization, capitalism, exclusion and punishment interact within gentrifying spaces such as Centretown, the larger “public city” is becoming increasingly threatened (DeVerteuil, 2012). While local government interventions can, in certain cases, help eradicate gentrification-induced displacement pressure for centrally located, non-profit social services through initiatives such as direct financial support and land use controls (DeVerteuil,

2012), these initiatives do not help mitigate displacement pressure for CHC clients. Meanwhile, though “staying put” and maintaining centrality in urban neighbourhoods is paramount for social service providers, resisting displacement pressure can also result in involuntary immobility, where services can become “locked in” to a particular location (with the inability to move and/or expand), while their clientele becomes displaced and out of reach of services (DeVerteuil, 2011).

### **Increasing socio-spatial tensions and inequitable health outcomes**

As gentrification continues to change the physical and social composition of urban landscapes, one common neoliberal discourse that is often attached to redevelopment policies and projects emphasizes increased “liveability” for neighbourhood residents. With gentrification carving out socio-economic spaces designed exclusively for the privileged, however, what may make a neighbourhood more “liveable” for some, can also render it inhospitable for others.

According to Rose (2004), the transformation of urban space through gentrification often results in “socially sanitizing” neighbourhoods “by removing the most marginalized groups from public space or eradicating their housing when it is located in neighbourhoods with potential for settlement by middle-class families” (p. 282). In other words, when the places vulnerable populations have traditionally frequented become no longer welcoming or liveable, they “may move as soon as they can, rather than wait for the inevitable” (Marcuse, 1985). One rooming house tenant living in a rapidly gentrifying neighbourhood in Toronto, for instance, expressed concerns in Mazer and Rankin’s (2011) study that even though he could afford to continue to pay his rent, he could no longer go to the park – or any of his other “‘most comfortable places’ to sit, read, relax, rest without people ‘giving’ [him] that eye” (p.822). The rooming house tenant said he planned to move out of the neighbourhood due to “increasing hostility from police and middle-class newcomers” (p.822), as he felt marginalized by living a parallel – but very separate life – to the more privileged type of residents who had moved into his neighbourhood.

Harm reduction program director Rob, who works in a neighbourhood where significant business and residential redevelopment has occurred in recent years, has observed some similar themes of hostility and exclusion emerging, as gentrifiers have increasingly moved into the area.

I think the problem with infilling, and gentrification, is that you’re bringing in people who haven’t really established this...ability to be in that same space with people who are acting in strange ways, or who are looking dishevelled, or things like that. They’re not accustomed

to it. Plus, some of this housing is quite expensive, so I think there's this sense of "I paid a lot for this, I should have to look at that" that comes with it. But if you talk to somebody who's been around for a long time, they may have, in the past, actually chatted with the homeless person who collects the recyclables out of their bins, and they just kind of accept that as part of the urban neighbourhood landscape for them.

While advocates of "social mixing" (a nineteenth-century ideal that the social composition of a neighbourhood population ought to reflect the diversity of the wider society) believe that an imposition of new social spaces can contribute to a more liveable city, Rose (2004) argues that the opposite is generally true. Instead, the social diversity that gentrification imposes creates and emphasizes tensions in regards to everyday living, through marked economic or lifestyle disparities between residents, "which can generate discomforting experiences of neighbouring... when the rich and the poor live alongside one another but frequent different places, participate in different social networks, and harbour different conceptions of their neighbourhood and city" (Rose, 2004, p. 281, p. 836), and cause those with less social or economic power to withdraw from public life. In the narrative above, Rob makes an important distinction between the concept of "social mixing" and the actually occurring displacement that he has observed within the context of his gentrifying neighbourhood. Here, the increased marginalization of vulnerable populations does not appear to occur due to marked social or economic disparities alone, as Rob recounts from his experience how more privileged, long-time neighbourhood residents view homeless populations, for example, to be part of the natural fabric of their neighbourhoods. In the case of gentrifiers, it is the intersection of social and economic privilege, along with the perpetuation of oppressive neoliberal discourses that is leading to the systemic exclusion or "sanitization" of vulnerable populations from public spaces. As more homogenous populations increasingly occupy formerly mixed-use, urban spaces in Ottawa, then, social tensions and subsequent displacement will continue to occur for those with marked economic or lifestyle disparities, who cannot navigate or afford to participate in new "liveable" spaces in the narrow ways in which they are intended.

Frontline worker Erica said that she has also noticed social tensions growing as a result of the "social mixing" of gentrifiers and long-time neighbourhood residents in the area around her own CHC. She said that she has seen and heard about blatant instances of exclusion and oppression of vulnerable populations occurring, which she believes can be linked to the neighbourhood's shifting demographics. With many homeless and lower-income populations still residing in the

area, for instance, many panhandlers are still visibly present along the main strip on any given day. This, said Erica, has meant growing tensions in the neighbourhood, as “a lot of people hate panhandlers”. She recounted one story told by an individual who volunteers at her CHC, and also works at a convenience store on Bank Street in Centretown, just adjacent to a popular panhandling spot:

I’m not sure of the exact details, but [this convenience store employee] found out that a woman who was in the store was calling 911 on a person who was passively panhandling [outside], and was like “Why are you doing that? He’s not doing anything”; and she was like, “I just don’t like to look at him”. And [the convenience store employee] knew, somehow, I guess, that she lived in that new condo that was developed”.

While the examples above discuss some of the indirect implications of “social mixing”, such as self-displacement and exclusion, Erica’s narrative demonstrates some of the more direct, oppressive outcomes that can be produced as a result of growing tensions between gentrifiers and vulnerable populations. The new condo development referenced by Erica is located at the intersection of Bank Street and Gladstone Avenue, at the former site of the Metropolitan Bible Church (closed in 2008). Because of the building’s heritage designation, the site’s current owner, Urban Capital Property Group, was forced to preserve a section of the facade for the commercial storefront that was eventually constructed – however, the drop-in services formerly available in this building are no longer in existence. The oppressive impact of this redevelopment project has thus been twofold: Not only did the displacement of this drop-in program result in the reduced delivery of social services for vulnerable neighbourhood residents, but it also symbolized the systemic replacement of former spaces of care with spaces of exclusivity. As a result, public spaces have become increasingly hostile and punitive for those who require access to the neighbourhood’s remaining health and social service resources.

[That church] was a real hot spot for folks to access to get meals and other resources...and then it was bought out by a developer and made into a condo. So that’s a really concrete example of people being pushed out of that space...that condo basically took over that space that was a real homeless connection space. Yeah, so these are the kinds of people – like, if you’re moving into Bank and Gladstone and you don’t have a fucking clue about the fact that there’s going to be a diversity of folks in this area...that’s *interesting*. And if you are moving in because you have an awareness and don’t *like* it...that’s also really interesting (Erica, frontline social services worker).

The entitlement and claim to space by neighbourhood gentrifiers can also be reflected in another encounter that Erica personally had with a new condominium owner in the area. She explained that her centre had recently run a youth engagement project, where they recruited some of the area's low-income youth to design a mural on the side of the parking garage attached to her CHC's building. After the wall in question was painted, Erica said she was approached by a condo owner who complained to her that the mural was impacting the sale of his condo, and that "when people go out on the balcony, they see it":

He was trying to be nice about it, but he was *so* not, right? He also interrupted me talking with a woman who was accessing me for essential services, which I didn't really like, and didn't let him interrupt me, but there's a lot of entitlement, right? And a lot of like, "you're fucking up my life" when it's actually a shared space.

Harm reduction worker Steve experienced a similar hostile encounter with the resident of one new condominium building, located in a gentrifying area where he regularly does outreach:

There's just a huge influx of condos around [the downtown core], so you see the tension between these people who have moved into this part and have sort of an entitled sense of the neighbourhood, and really push hard back against people. We had one guy who was president of the condo association for the building across from the Salvation Army shelter – which is one of our busiest stops – and he would come out there every day with a video camera like, filming us, swearing at us, and yelling at clients who were picking up harm reduction tools.

While Rose (2004) wrote about a type of social mixing imposed by gentrification that causes vulnerable populations to feel discomfort and practice self-displacement due to growing social tensions and unequal power dynamics within urban neighbourhoods, the above examples show the oppressive repercussions for those vulnerable populations who continue to attempt to navigate public spaces which are no longer "theirs". The subsequent barriers to service delivery and accessibility that emerge appear to be having a direct, detrimental impact on the health outcomes of vulnerable CHC clients:

[The interaction with the condo owner] is one example of like, "oh, this is a new kind of thing I need to prepare for in my work". I needed to spend half an hour with him instead of half an hour with someone in crisis. So you know, I'm getting paid to appease the condo owner versus getting paid to do my job (Erica, frontline social services worker).

According to Steve, the ongoing confrontations he experienced with the condominium board president (discussed above) reached a boiling point, when a “massive drug bust” and series of arrests occurred one summer in the neighbourhood surrounding the aforementioned condominium. In a press conference following the drug busts, said Steve, Ottawa’s chief of police explicitly credited the condominium board president for assisting with the crackdown.

You have these new condo owners pushing police to put pressure on people they perceive as not being in the neighbourhood, or being somehow...not entitled to the space. And then, disruption to the drug market is huge in terms of healthcare. Anytime [a crackdown] happens, you see higher rates of overdose – you have the suppliers that people are used to being on the street, gone – so new people come in with new supplies. Actually, a week after that bust happened this summer, there were like, six near fatal overdoses.

Rob recounts one particularly harmful example of how the increasing exclusivity of public spaces within urban neighbourhoods is putting the lives of intravenous drug-using populations at risk:

I’ve heard that the [area’s] shelters have experienced some more problems with the condominiums [than our CHC; which is located a few blocks further from the majority of the new condo developments]. I mean, we’re losing a lot of public space and even like, the place where people used to go to hide their behaviours are now being fenced in. So it’s hard to find an alleyway, it’s hard to do anything that isn’t public at this point, as we’ve kind of [been experiencing] more privatized public space all the time. This pushes behaviour into semi-private places...so that’s why, you know, injecting in washrooms is becoming the only reasonably safe place that people can find.

With tensions between gentrifiers and vulnerable urban neighbourhood residents continuing to grow, the visible shift in neighbourhood demographics is posing a dilemma for social service workers like Erica. She said she is torn between whether she should try to engage and educate neighbourhood gentrifiers in dialogue in order to mitigate oncoming marginalization, and acknowledging that this type of outreach and engagement would detract from her capacity to distribute critical health and social services to clients:

We’ve [at our CHC] often thought like, should we engage more with condos? Should we do advocacy? But you have to remember; we have no energy and no time because we’re already inundated with doing real work. So it’s really hard for me to prioritize the needs of condo people.

Through the narratives of social service workers included in this chapter, it becomes clear that gentrification's impact on the health of vulnerable populations has many dynamics and lines of force. As gentrification interacts with neoliberal discourses in different urban Ottawa neighbourhoods, oppression is produced for vulnerable CHC clients through a multitude of barriers to accessibility and delivery of social services, which manifest both similarly and uniquely, depending on the neighbourhood context. While there is existing literature that theorizes how geographical place, processes of gentrification, and neoliberal governance all interact to create additional, oppressive barriers for vulnerable clients, the narratives in Chapter 3 explain how these oppressive barriers are having a particular, negative impact on how community-based health services are accessed, distributed, and planned within Ottawa neighbourhoods.

With gentrification projects continuing to intensify in the nation's capital, it becomes critical for CHCs and other community-based services to re-evaluate certain policies, community engagement and social services distribution strategies to ensure that the vulnerable populations they have long committed to serving have the opportunity to experience equitable health outcomes. However, as Chapter 4 will explore, the interaction of neoliberal discourses and gentrification is not only producing oppressive outcomes for vulnerable populations *outside* the walls of urban CHCs, but inside these centres as well.



#### **Chapter 4: Service delivery's disappearing ethics of care**

I was doing outreach at Operation Come Home, encouraging young folks who are really oppressed and living with a lot of shit to come access our services. One individual – a young woman, who was in a place of transition – started coming to tai chi with the intention of learning coping [mechanisms] other than the habits that she was identifying as being harmful for her. The way in which she participated in the class wasn't disrespectful in the context of, you know, swearing or [violating] the boundaries of others...but you know, in tai chi you have to follow the moves, and she was kind of doing her own moves...I think she was jumping up and down a bit to help her focus. I'm not saying that isn't distracting...but the tai chi instructor basically said "if she continues to come [to this class], I'm not going to teach it anymore". So we were in this place of like, "well what the fuck?" It shows that we don't really train the people who are running the programs to be competent and accepting of all folks and all kinds of behaviours. [Making accommodations] is not something we do very well here, and that's something we need to start doing - because if we just keep [programs] mainstream, we're only going to attract the condo people. We need programs for people who have nowhere else to go, because they can't afford it, or because [other] programs aren't set up to accept them. So for me that was like, "oh – I can't really do outreach with certain populations anymore about programs that aren't homeless-specific, because we're not ready for them".

(Erica, frontline social services worker)

As downtown Ottawa neighbourhoods continue to undergo significant geographical and demographical transformation through processes of gentrification, opportunities for equitable access to and delivery of health and social services for vulnerable populations are becoming increasingly limited. While axes of oppression such as displacement, increased police presence within neighbourhoods, and growing privatization of public spaces have arguably made the need for community-based health and social services more critical than ever, growing inequities are now being produced *within* urban Ottawa CHCs as well as outside of them, as both vulnerable clients and staff become governed and marginalized in problematic new ways.

In the above example, Erica, a frontline social services worker, indicates that her CHC may be ill equipped to mitigate the growing needs of its clientele in the face of neighbourhood gentrification. With the exclusion of vulnerable populations from urban public spaces increasing at the same time that community-based resources disappear, Erica expresses concern that discourses of "deserving" versus "undeserving" clients (Gray et al., 2015; Liebenberg et al., 2015) are being perpetuated by staff at her CHC. Her narrative highlights the potentially problematic and oppressive outcomes that can be produced by CHCs when a growing need for accessible, inclusive programs interacts with an increasingly neoliberal social services environment.

While Chapters 2 and 3 use examples from academic works as well as narratives from social workers to argue how the interaction of gentrification and neoliberal/neoconservative discourses produces social and health inequalities for vulnerable neighbourhood residents (often, by creating delivery and accessibility barriers to social services), what is missing from current literature is an analysis of how further oppressive outcomes can be produced through clients' interactions with social services, themselves. As neoliberalism and gentrification interact outside CHC walls to produce increased marginalization for vulnerable clients, some CHCs are simultaneously reproducing that marginalization through growing regulation (and punishment) of “undeserving” clients; the re-structuring of programs to cater to the more privileged, homogenous populations moving into the surrounding gentrifying neighbourhood; and the increased marginalization of social service workers who still adopt an ethics of care. This chapter explores what happens to service delivery, the autonomy and governance of frontline workers, and the ultimate health outcomes of vulnerable CHC clients when neoliberal discourses and processes of gentrification intertwine within spaces of care.

### **The importance of community health centres as spaces of care**

Rooted in the civil rights movement, the core visions and mandates of CHCs have traditionally been centered on social justice-oriented goals such as creating environments of strong community support, and eliminating health disparities (Lefkowitz, 2007). The missions of many Canadian CHCs today still generally affirm the foundational values of those first centres established in the 1960s, by positioning themselves as inclusive, accessible and empowering. Below are the current mandates of two CHCs based in urban Ottawa neighbourhoods:

“We believe in an integrated approach to care that is holistic, non-discriminatory, caring, and innovative. Collaboration is imperative to us. This fosters the clients' and the communities' control over their increased wellbeing. We also believe that our open doors should lead to the vast network of services available. By working together, we make it easier for clients to navigate the healthcare network.”

(Centretown Community Health Centre)

“We support people and communities to enjoy the best possible health and well-being. We do this by providing primary health care and social services, and promoting access to the social conditions that influence health, such as housing, food security, employment and civic engagement. We remove barriers to accessing services for people who are vulnerable

because of their age, income, abilities, sexual orientation or gender identity, and language or culture.”

(Somerset West Community Health Centre)

Providing empowering, accessible health services to a diverse and vulnerable clientele is at the core of these mandates, with an emphasis in each case on an equitable approach to care that considers the different needs and intersecting oppressions faced by those accessing community-based care. Under these mandates, any client should expect to receive empowering care that is not purely medical, but inclusive of “practical or emotional support” (Milligan & Wiles, 2010, p. 737). To achieve health equity, Milligan & Wiles (2010) argue, “care entails a complex network of actors and actions involving multidirectional flows and connections” (p. 737), where both recipients and providers are involved in the co-production of care. In this regard, in addition to their provision of important primary health services, many CHCs have traditionally provided inclusive spaces that foster a sense of community and collaboration.

Harm reduction program director Rob said he believes that if vulnerable clients feel care is being designed for them and delivered in an empowering environment, they are more likely to access it. He said many of his drug-using clients often make statements to him about the life-saving potential of programs and services offered through his CHC, from both a practical *and* emotionally supportive context:

Clients will quite regularly make the statement that, you know, “this program or these services saved my life”.... “this is the only place where I feel accepted”... “I feel like I belong”. This is the place where people can kind of be themselves without fear of judgment, and that’s really, really important to us.

Rob’s account mirrors a narrative expressed within Conradson’s (2003) study, which analyzes the significance of drop-in centres as integral spaces of care within the city of Bristol, England. In this study, one participant (a client who regularly accessed community-based drop-in services) reported that his positive sense of self was reflective of the acceptance and respect he was met with when he stopped by his neighbourhood drop-in centre. Drop-in programs – which have traditionally been offered as core CHC services – can be understood not only as spaces through which primary healthcare can be accessed, but as spaces embodying an *ethics of care*, which can enable growth and self-development amongst clients (Conradson, 2003). In his study, Conradson (2003) cites a number of instances where participants used their neighbourhood drop-in program

as “an environment through which to temporarily distance themselves from domestic sources of frustration and difficulty” (p.519). In both Rob and Conradson’s (2003) accounts, primary care and positive social interactions are framed as intertwined, and equally important factors in achieving both health equity and social justice for vulnerable CHC clients.

Not only are CHCs important in the sense that they can provide a safe, community-oriented space through which vulnerable populations have equitable access to care, but some frontline workers say that their centres also have the potential to help break down certain unequal power dynamics that can exist between vulnerable and privileged neighbourhood residents. Housing case manager Chris, for instance, believes that his CHC’s ability to offer diverse services to populations facing a number of different oppressions is paramount in helping to mitigate some of the inequalities and injustices that can emerge within a mixed community:

We have a very varied clientele in our centre. We have people who inject drugs, and who are street involved...all the way to diplomats. Sometimes, they’ll all be in the same waiting room. So once you point that out to people, they tend to...respond differently, because they’re like “oh yeah, I was in that waiting room – no one attacked me, no one mugged me, nothing happened. So that really helps.

Rob agrees with Chris that building community trust is an important capacity of CHCs. He added that the ability of his centre to introduce more “controversial” programs has often depended on “community buy-in”. Over the last few years, for instance, Rob has been spearheading a series of community consultations to enable the establishment of Ottawa’s first supervised injection site within his centre<sup>6</sup>. While he expresses frustration that the process has been arduous, he believes that his CHC has played an important intermediary role in helping to mitigate some potentially exclusionary discourses and practices within the surrounding neighbourhood:

As a broader community health centre, we are in the community not just for the drug users or the disenfranchised populations, but for other people in the community as well. We definitely occasionally may need to leverage that when they say something like “I’m not so sure about [my CHC] handing out crack pipes, or starting supervised injection services, but we trust them, because they’ve been with us all along in this community, and they’ve supported some really important initiatives to us” (Rob, harm reduction program director).

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<sup>6</sup> On July 26, 2017, the federal government approved Sandy Hill Community Health Centre’s application to establish Ottawa’s first supervised injection site. The site is expected to be up and running by Fall 2017.

As neighbourhood gentrification continues to increase at a rapid pace in downtown Ottawa – bringing with it an influx of privileged new residents to previously mixed-use neighbourhoods – Rob’s example demonstrates the importance of maintaining community-based, equitable spaces where a diversity of bodies can co-exist and interact. Not only do these spaces of care have empowering potential for vulnerable populations, but they can also help to diminish entitlement to space and the perpetuation of neoliberal discourses amongst more privileged residents. For many of the vulnerable populations who remain in gentrifying neighbourhoods, but cannot afford to participate in (or feel disenfranchised from) the landscape’s increasingly privatized and exclusive spaces, some frontline workers see the role of CHCs becoming arguably, more important than ever.

According to Murphy et al. (2008), gentrification functions to compromise two key community health values: health protection (the ability of healthcare providers and communities to be resilient while facing transformation) and health equity (the fair distribution of health determinants, outcomes and resources). For frontline worker Steve, it is crucial for CHCs to not only maintain – but to enhance – their role in urban neighbourhoods as providers of equitable, community-based spaces, amidst ongoing socio-spatial transformation:

People are feeling pushed out of every space. I mean, spaces are increasingly privatized, so it’s important, I think, to have that common, shared space that people can go to and have a sense of like – they can just be. They don’t have to be doing anything, just somewhere where they’re not getting harassed [...]. There’s solidarity already in the community, but providing a space for it to happen is really critical.

As processes of gentrification and overarching neoliberal discourses continue to create both social and physical barriers for vulnerable populations within downtown Ottawa neighbourhoods, it is clear that CHCs must take oppressive socio-spatial changes into account during the planning and delivery of critical health and social services, to ensure they are meeting the growing and shifting needs of marginalized clients. Despite CHCs’ mandates centered on the championing of social justice work and their long histories of providing care within inclusive spaces, however, research participants in this study have identified a growing disconnect between the traditional role of CHCs, and some of the current, oppressive practices and discourses that exist within centres. Several of the narratives that follow support Conneely and Garrett’s (2015) argument that social service workers in a neoliberal climate are increasingly viewing social justice as something adjunct – rather than central – to their primary role(s).

## **Growing accountability to funders, decreasing accountability for care**

In the early 1990s in Canada, increasingly neoliberal policy-making significantly shifted the burden for social service delivery from government bodies onto autonomous, community-based providers. During this era, government funders began to move away from delivering services through their own organizational bodies, and more towards the practice of “contracting with community organizations for specific services” (Eakin, 2007, p. 1). In 1994, for instance, the federal government began a review of its funding to non-profit organizations, which led to billions of dollars in cuts, and the replacement of the federal Canada Assistance Plan with the Canada Health and Social Transfer (1996). In Ontario specifically, CAD\$772 million in funding cuts to the non-profit sector were made in 1996 alone (Chouinard & Crooks, 2008). With social services funding across Canada having been continually slashed for two decades, and responsibility for health and social services provision falling more and more on non-profit, community-based organizations, a number of compounding factors are now limiting these organizations’ capacity to provide equitable services for a diversity of populations.

Initially born out of a market response to large-scale governmental cuts to health and social services, non-profit organizations like CHCs now being drawn into the very neoliberal systems that created the overarching need for community-based care in the first place. Baines (2010) classifies this restructuring of the non-profit services sector as a “growing convergence between private and non-profit enterprises in terms of ideology, managerial models, and styles” (p.10). Social services, said Baines (2010), “can be stripped of their collectivist content and delivered in bureaucratic, standardized ways that demobilize and disempower those who provide services as well as those who receive them” (p. 11). In defining the scope of non-profit social services, Woolford & Curran (2012) situate these organizations and programs within the bureaucratic field:

It is within this social space that non-profit actors seek resources such as funding or access to clients, fill service gaps left vacant by the rollback of welfare provisions, and embody practices that will allow them to appear competent before funders and other resource gatekeepers. Thus, the conditions of the bureaucratic field structure and shape contemporary social service practice (p. 45 – 46).

Though many community-based services were initially established in response to governments’ handing off of responsibility for social services provision, provincial and municipal bodies in

Canada still make up a large portion of these organizations' funding bases. While social services have never been completely separated from market conditions, the current neoliberal era presents new dangers for vulnerable populations, as overarching discourses around individualization within social services organizations "discourage activities that target unjust social conditions rather than risky and irresponsible individuals" (Woolford & Curran, 2012, p. 46).

Overall, Baines (2010) argues, the increasing adoption of more "business-like" strategies by non-profit organizations has overall "supplanted discourses of collective care, economic equality, and social solidarity" (p. 12). One significant business practice that is functioning to govern social services organizations and their clients in increasingly oppressive ways is CHCs' growing accountability to funders. For those who are the chosen recipients of government funding, the increasing pressure to be "accountable" to and model "best practices" (Woolford & Curran, 2012) has become paramount, as the survival of social services institutions continues to depend more and more on their ability to align themselves with neoliberal discourses:

Service providers are seldom able to operate offloaded services in an autonomous manner, since the funding relationship developed through offloading is framed as a partnership with government, and partners are expected to work in a cooperative manner, meeting their shared objectives (Woolford & Curran, 2012, p. 49).

In the face of gentrification, the lack of capacity that funders generally give community organizations to adapt programs and re-allocate funds to meet changing local conditions and/or unjust circumstances is especially problematic. When displacement, disenfranchisement or other new oppressions emerge for vulnerable populations within a neighbourhood context, the health and social needs of these populations can change significantly. From a social services delivery perspective, this signals the need for CHCs to re-evaluate or modify services to ensure that vulnerable clients are able to continue to access the care they need. However, according to Eakin's (2007) study of grants provided to three community service organizations in southern Ontario, 55% of grants provided agencies with little or no ability to adjust programs or spending to accommodate changing conditions, while 42% of grants only allowed for changes that were pre-approved by the funder (in most cases, this approval is very difficult to obtain). Overall, only 3% of grants were found to have some flexibility in that they allowed the agency to adjust programs to meet changing circumstances. Not only are CHCs limited in their ability to shift programs and services to address the new and growing needs of vulnerable clients, but Erica perceives an

increasing lack of autonomy in her own role to use existing resources to empower vulnerable groups or individuals who may be seen as “contentious” or “high-risk”:

I know that the Ottawa Panhandler’s Union is starting up again and it’s struggling...it’s really struggling. And part of me is like “ugh, as an agency I should be affiliated with them, give them resources, help find honorariums to help encourage people to attend [meetings] who are panhandlers. That’s the kind of work we should be investing money and time in [...] but it’s a bit too contentious. I just wish I worked in a place where it was like: “Guys, I’m going to join the Panhandler’s Union, can I have \$500 to help support them?” I mean, I know that’s not realistic, but if there wasn’t *so* much education needed and *so* much reassurance....and I can’t provide that reassurance, because part of what they’re going to be planning is disruptive tactics. So we can’t really be affiliated with them.

In this example, Erica’s desire to support a local union that advocates for panhandlers has not been rejected outright, but she anticipates this sort of activity would not be in the best interest of accountability to funders; and thus practices self-governance by avoiding making a request to CHC management. In addition to the restrictions placed on CHCs as a result of growing accountability practices, the perceived restrictions simultaneously placed on social services workers as a result of overarching neoliberal discourses limits the potential for health and social equity for clients.

In a rare study which demonstrated community-based social services organizations *positively* responding to the needs of vulnerable populations in the face of a changing socio-spatial environment, the majority of institutional funding in each respective case largely came from private funders. Meerman and Huyer’s (2014) analysis of organizational response to neighbourhood gentrification in Grand Rapids, Michigan, showed evidence of types of responses including the expansion of particular services such as transitional housing, and the provision of more holistic support through substance abuse treatment programs. The flexibility these organizations had to shift programming and re-allocate resources can be linked to the fact that only two out of the thirteen organizations studied received public funding. For Ottawa-based CHCs, which are mostly funded by public dollars (mainly, provincial and municipal), it can be surmised that there is very little capacity to alter services and programs to keep pace with changing socio-spatial conditions.

Erica believes that the increased shift towards accountability to funders within her own CHC has been detrimental to the overall health of some of her centre’s most vulnerable clients. She perceives the shifting way that she and her colleagues are governing themselves under a stricter



accountability model to be translating into a decreasing ethics of care within her centre as a whole:

There's a huge, paranoid sentiment among, I think, a lot of community health centres, around accountability [...] and it's been noticed by a lot of employees here, around this [CHC] becoming more and more corporate. I think it's good to be responsible, and to ensure that we are accountable, but you don't need to have it be like, *so* accountable that we're not doing anything. We may as well not be funded and not working if all we're doing is being accountable, and not doing any real work.

In addition to the risk of health inequalities emerging as a result of the growing inability of social services workers to adapt programs to meet changing demands for care, the increased administrative burden that growing accountability places on CHCs also means that the limited time and resources of staff to offer already established programs and services is becoming additionally strained.

According to Eakin (2007), the work of community-based non-profit organizations is becoming “buried under administrative demands, mired in regulations, and supported by unstable short-term funding that too often fails to keep pace with rising costs” (p.45). Along with onerous reporting requirements, other factors within this shifting funding climate that are functioning to oppress and limit social services programming and delivery include more project-based funding (and less broad, ‘core’ funding), which gives funders increased control over what an organization does with its money. Other changes include less long-term funding, which makes it difficult to plan strategic, multi-year projects (Chouinard & Crooks, 2008; Scott, 2003). Overall, this sort of uncertainty and volatility in regards to funding can lead to detrimental health impacts, as the shifting needs of vulnerable CHC clients are positioned to be systemically unmet.

### **Fewer voices to support the vulnerable**

As stringent accountability processes make the securing of funding and resources increasingly difficult for individual CHCs, previously existing networks of care are simultaneously disappearing within neighbourhoods, leaving the overall social services landscape fractured. In Chapter 3, Jennifer, Erica and Steve discussed the importance of informal, community-based networks in the context of health provision for vulnerable populations, with local partnerships and sharing of resources often helping to fill service delivery gaps and mitigate the impact of ongoing neoliberal funding cuts within CHCs. Participant narratives discussed how the interconnectedness

of urban-based community services is so integral that if one drop-in centre loses its funding or is displaced, it is likely that a neighbouring centre will indirectly feel the impact of the loss of staff or services. Among the many unjust outcomes associated with the loss of neighbourhood resources and networks of care is the shrinking ability (both real and perceived) of staff to advocate on behalf of clients.

According to Erica, having many different social services organizations present within a particular neighbourhood offers a diverse range of capabilities in terms of potential advocacy and collective action. Opportunities for social service workers to pool resources and collective power to achieve social and health equity for vulnerable clients has become limited, however, due to gentrification-induced displacement and neoliberal funding cuts:

[Before their recent move away from this neighbourhood], AIDS Committee of Ottawa [was] fantastic, because they have way more ability to be progressive, and more radical and vocal because of the nature of their funding; whereas we're really constrained by funding and by affiliations with the police. Having allies like that when there is a crisis, and being able to say, "as agencies on Bank Street, we stand against the criminalization of folks living or panhandling in the area" [is important]. The more you lose those people because they're not really in the area anymore, that makes your voice smaller and your ability to advocate that much less (Erica, frontline social services worker).

In this example, the loss of resources that Erica's CHC experienced as a result of the AIDS Committee of Ottawa vacating the neighbourhood was difficult to quantify, but could be described in terms of a loss of advocacy power. With so little flexibility already in regards to social services organizations' ability to adjust programs to reflect changing socio-spatial conditions (Eakin, 2007), the diminishment of collective power makes it even more difficult to achieve empowering change through community-based initiatives.

While collective power to advocate for vulnerable populations is disappearing, the increasing dominance of neoliberal discourses around individualism and competition appear to be interacting with demographic shifts within CHCs, to produce further oppression for vulnerable clients.

### **Governing "undeserving" bodies**

In the face of limited resources, increasing accountability measures and loss of community networks, the practices of CHCs are becoming more closely aligned with neoliberal discourses, as they attempt to retain their place within the transforming urban landscape. Through this alignment, CHCs are shifting further away from an overarching ethics of care, as programs and

services become centred more on what would be most “uncontroversial” to funders, rather than what initiatives would provide the most vulnerable clients with the most equitable care. As a result of this shift, the neoliberal dichotomy of “deserving” versus “undeserving” (Woolford & Curran, 2012) that organizations are often subject to when it comes to receiving funding gets problematically passed on through some CHC staff, who, according to research participants, are increasingly governing the behaviours of vulnerable populations and subjectively determining which bodies are most “worthy” of receiving services.

Under neoliberalism, the push for vulnerable clients to become “self-providers” becomes much more pronounced. Rather than advocating for vulnerable bodies in practice, all of the attention of social services organizations now becomes focused on reforming the individual, rather than challenging the more systemic and structural factors that have marginalized vulnerable bodies in the first place (Lyon-Callo, 2004; Wacquant, 2009). Through these marginalizing discourses, clients who are able to comply with the rules and defined boundaries of services like drug counselling, scheduled appointments and social programs are seen as successfully engaged (Liebenberg et al., 2015), while those don’t are seen as unworthy and/or undeserving of the services altogether. Under this framework, both accessing and *retaining* services now become the responsibility of the individual client (who must govern his/her self appropriately), rather than the responsibility of CHC staff.

Frontline worker Steve said that he has noticed staff tolerance for “bad” client behaviours within his CHC lower significantly in recent years. When it comes to clients who access harm reduction drop-in services in particular, he said he has observed a growing trend of vulnerable populations being “barred” from his centre for speaking or acting in certain ways:

[Staff] are very quick sometimes to suggest that someone has to get barred [from the centre] because they didn’t speak to someone else in a polite way, for example. Which to me is just like...you know – this person is sick; they feel like they’re crawling out of their body right now because they’re in withdrawal, and [staff] are worried about them not saying “thank you”, or greeting them, or for telling them to fuck off...but like – it’s part of your job. So we’ve seen a lot of people get barred, and it’s very much based on this perception of “oh, he’s a [harm-reduction] client? Or “he looks a certain way?” They can have the liberty of booting him out – which I think they would certainly think twice about if it were someone else (Steve, harm reduction outreach worker).

For substance-using populations who are already amongst the most disenfranchised and marginalized within society, being rejected from spaces of care that are meant to act as

empowering refugees from external oppressive forces, can take a detrimental toll. Already subject to self-governance within gentrifying areas outside CHCs (where they must be cognizant of behaving in certain ways so that they do not get picked up by the police, for example), the increased surveillance and punishment of so-called “undesirable” behaviours within CHC walls can result in the avoidance of critical healthcare services altogether. In Steve’s example, his CHC appears to be mirroring oppressive exterior, socio-spatial conditions such as the increased policing and punishment of vulnerable populations who display behaviours that conflict with those of the neighbourhood’s homogenous new demographics. Just as processes of gentrification are re-building neighbourhoods in ways that systemically exclude vulnerable populations, CHCs, too, appear to be embodying shifting discourses that are resulting in the exclusion of certain bodies from spaces of care.

In addition to the unique incidences he has observed of staff barring individuals who exhibit “bad” behaviours from CHC spaces, Steve said that he has also seen a trend within his centre of staff trying to remove entire groups of vulnerable clients from public view, in order to “minimize disruption” to more “mainstream” clients and staff. After advocating for a long time to establish a harm reduction drop-in program within his centre, for example, Steve said that a space was eventually allocated for the purpose – however, the physical location of the space is indicative of his CHC’s view of illicit drug-using clients:

One of the things we were pushing for, for like three years was to get our own drop in – because we’ve kind of operated out of a room that was really tiny. So we finally got this drop-in – and that’s worked well in some ways, because we’ve tried to make ownership to the clients; it’s their space – but in some ways, it feels like it’s almost segregated. At one point it was proposed we might be positioned in the front of the building and there was *huge* opposition – some staff even started a petition saying that they didn’t want this drop-in to be there, because it would be too disruptive to the front desk, and – you know – that are clients are disruptive and all that [...]. We ended up getting a room in the back. They knocked down a wall and stuff, which I’m happy with – it’s a bigger space – but yeah, it still sort of felt like...ok, yeah, just put them in the back.

By petitioning to position those who access drop-in harm reduction services at the back of their centre, staff communicated a clear message that only a particular sort of client is acceptable within the CHC’s more visible, public spaces.

Neoconservative discourses that position vulnerable clients as dangerous “Others” and promulgate the need for increased surveillance and policing of “undeserving” bodies are also

becoming more apparent to Erica. She said that she has perceived growing hostility directed by staff towards some of the vulnerable clients who access frontline services through her CHC's community room. This room, originally meant to be a supportive, inclusive space has become increasingly policed and exclusive, as the foremost focus of staff appears to have shifted away from providing inclusive, intersectional care:

I had so much pushback about a lot of the stuff I did in that space, because people perceive that room to be a *danger* room. There certainly are incidents: People are coming from the Ontario Works office, or anywhere else; they're extremely stressed...*of course* they're going to slam the phone down here and there. That's the reality of *this*: Working in an urban community health centre. I think what the problem is, is that we're so used to, like, "we don't want any incidents to happen, ever", versus like, "let's work on accepting that [incidents] *are* going to happen (Erica, frontline social services worker).

Erica added that her executive director has also explicitly emphasized the need for there to be "fewer incidents" within the centre overall:

The emphasis for us is not on providing support. It's on providing a smooth environment. It's on providing a safe environment – not necessarily for the folks who are coming to see us, but for the folks who are working here.

CHC staff members, of course, have the right to workplace safety (which can tangibly be put at risk by violent or unpredictable clients), and reasonable limits when it comes to the type of incidents or behaviours they should be expected to endure within their professional roles. While frontline workers should certainly not risk their own personal safety by tolerating violent behaviours, as Erica's narrative implies, what *is* problematic about the perceived shift within her centre towards prioritizing the health and safety of staff members, is that the subsequent health and safety of vulnerable clients appears to be simultaneously *deprioritized*.

In both of their narratives related to the growing exclusion of "undeserving" clients, Erica and Steve highlight some of the oppressive health outcomes that can result from neoliberal/neoconservative discourses and gentrification interacting within a social services context. While gentrification causes displacement and disenfranchisement of vulnerable populations within urban neighbourhoods, neoliberal funding cuts and growing accountability to funders render CHCs unable to adapt programs to fit the growing and shifting needs of clients. Meanwhile, associated neoliberal discourses around independence are enforced through neoconservative practices such as increased policing, punishment and removal of bodies that no

longer fit the increasingly homogenous profile of the “deserving” CHC client. Rather than dedicating resources towards exploring how new, intersecting oppressions may be contributing to heightened tensions or “disruptive” behaviours amongst vulnerable clients (and adapting services accordingly), some CHCs are simply cutting these clients off from services altogether. Through increased governance and exclusion of vulnerable clients, the formerly “public” spaces of care that previously existed within CHCs now appear to be increasingly privatized and homogenous. Much like the ongoing privatization of public spaces occurring outside CHC walls, this process functions to create more “sanitized” and “liveable” spaces for gentrifiers, while effectively putting the health of vulnerable neighbourhood residents at risk.

While staff members described in the above examples cite a perceived fear of physical danger to themselves and clients as a justification for the increased governance of vulnerable bodies, more symbolic actions are also being taken by CHCs which demonstrate their shifting focus to deliver services primarily to more homogenous, “deserving” clients. Steve said that a monthly newsletter he has long been self-publishing through his centre (mainly targeted towards harm-reduction clients), for instance, recently became censored. He said his management told him the language and subject matter in the newsletter was no longer “appropriate” to be displayed on the CHC’s website. The community-based newsletter, which was previously distributed to clients in a printed format (as well as published online), provides important resources and information to clients, including program drop-in hours, tips on safe use of fentanyl, legal support resources, and information about other neighbourhood social services. Written in informal language, the newsletter also provides empowering opportunities for vulnerable clients to assert their voices, by encouraging them to submit their original artwork, poetry and other content:

When there was a recent crackdown in the [Byward] Market, [the newsletter] basically had a list of like, how to connect with ticket defense programs, and it used the word “cops” in it...and someone in upper management was like “this is not appropriate language”. There was also someone who wrote about the spring thaw, and you know... “remember to throw your needles into the disposal bins....with stuff melting away now, you find all kinds of things, from dog shit to syringes” – and [management] was like “I can’t believe they used the word ‘shit’” – like, are you for real? We used this language for three years in this newsletter, and now somebody says it’s not appropriate, and my boss was just like “okay, we’ll stop putting [the newsletter] on our website and we’ll just give it to people directly” (Steve, harm reduction outreach worker).



*Fig.1: This monthly newsletter distributed through Steve's harm reduction networks is a collaborative effort between CHC staff and clients. It offers important information regarding resources, alongside art/poetry submissions from clients. Previously distributed in both print and online, the newsletter is no longer published on the CHC website. This change can be interpreted as reflecting the CHC's shifting policies and programs, which cater more exclusively towards neighbourhood gentrifiers.  
(Provided image)*

The decision made by management at Steve's CHC to no longer publish this community resource on its public-facing website signals a shift in the population to whom this centre now sees itself as accountable. Though Steve says the newsletter is still being physically distributed to his centre's harm reduction clients, the removal of the voices of marginalized populations from a larger, online platform now renders these populations increasingly invisible and voiceless within the larger community. This type of governance and oppression of marginalized clients becomes exacerbated as neighbourhood gentrification continues to attract more homogenous populations – and more “deserving” CHC clients – to the area.

As gentrification and neoliberal discourses interact within the CHC context to produce these binary definitions of “bad, undeserving” clients and “good, deserving” clients, those who fall into the former category are at risk of becoming further marginalized and oppressed within increasingly exclusive urban spaces. Meanwhile, though neoliberal funding cuts and growing accountability measures make it difficult for CHCs to adapt programming to meet the shifting

needs of those clients negatively impacted by processes of gentrification, the example below demonstrates how one CHC still appears to have some flexibility to introduce new programs for more privileged, homogenous clients.

### **The capitalization of care and the neoliberal CHC**

Although they may now be positioned at the back of his CHC, away from more “well-behaved” or “deserving” clients, the illicit drug-using populations who access Steve’s drop-in program serve as a metaphor for the needs of all vulnerable populations impacted by gentrification: They may be increasingly displaced from public view, but their health and social services needs are ever-present. While some staff members at Steve’s CHC may have wanted to limit the visibility of these clients by relegating the centre’s harm reduction program to the back of the building, he said that the total number of visits to the drop-in program has, in fact, tripled over the past three years. This demonstrates the continued need for diverse, community-based services in gentrifying neighbourhoods, despite the ongoing displacement and *replacement* of different marginalized groups. Rather than focusing attention on the continuing and growing needs of vulnerable neighbourhood residents, however, some CHCs are now shifting the focus of their programming to accommodate the new demographic of more privileged clients, instead.

One particularly poignant example of how CHC programming is failing to accommodate the shifting needs of vulnerable clients comes from Steve, whose centre recently opened up a second branch in a neighbourhood located on the periphery of the downtown core. This neighbourhood, which is adjacent to the one in which his main CHC operates, has, in recent years, undergone significant processes of gentrification – and, according to Steve, has become increasingly attractive to middle-class families. Although his own urban centre has been the primary administrator of safe inhalation kits since the City of Ottawa cancelled its controversial crack pipe distribution program in 2007, for instance (CBC News, 2007), Steve noted that this new centre has chosen *not* to operate harm reduction programs whatsoever:

They’re not even willing to give out any supplies. It’s not that we need like, an exchange route, but they aren’t even willing to get a needle drop box outside, right? Which to us, and [our] clients is a real slap in the face. It’s just hypocritical – we’re leading this harm reduction program, and then we can’t even have it within our own walls, in a centre that we run? That sends a message that the health care of drug users is not a priority and not applied universally.



With the number of clients accessing harm reduction programming having recently tripled at Steve's home branch, the need for increased resources in this area is apparent. However, as the above example demonstrates, significant financial resources are being put towards programming and services at this new centre, instead, which largely neglect to serve the needs of illicit drug-using populations. While this new CHC branch offers typical, community-based programs such as primary health care services and a youth drop-in program, drug-using clients who live in closer proximity to this new branch must still travel to the original CHC to access its needle exchange program and obtain safer inhalation supplies and services<sup>7</sup>. Reversely, some important primary health services once delivered at the original CHC branch have now moved to the new location; creating a scenario where those who require access to diverse services (once previously accessible at a single location) may now have to travel the two kilometers back and forth between branches. According to Jennifer (who works with Steve at the CHC's original branch), some of her clients who experience mobility issues have been frequently – and explicitly – expressing to her that the location of the new centre has posed increased barriers for them in terms of their ability to access services:

I keep hearing from clients *all* the time – that they don't want to go to [the new centre] to get to their doctor; that it's too hard to get there. *All the time* – all the time, all the time.

The segregation of health and social services not only functions to exclude certain populations, but it also diminishes the traditional mandate of CHCs, which is to offer a diversity of services to reflect the intersectional needs of clients. Those who look for support through food bank services at this new centre, for instance, may also require convenient access to needle exchange programs. Not only does this lack of proximity to diverse, critical services mean a continued accessibility issue for some, but as vulnerable populations continue to be displaced further and further from urban areas, they may no longer be entitled to services offered by their former CHCs altogether, due to geographical restrictions imposed by centres. The fact that more suburban CHCs, like this new branch, are tailoring services towards more privileged, homogenous populations only, is problematic, considering ongoing population shifts caused by gentrification. While the second

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<sup>7</sup> Other critical health services that did not translate from the original CHC to the new branch include anonymous HIV testing and cultural programs.

branch of this CHC had the original intent to serve the diverse needs of the area's more vulnerable populations, Jennifer said that she and other staff have observed the programming focus of this branch shift towards serving the more homogenous populations who are now moving into the surrounding gentrifying neighbourhood, instead.

It's kind of an inside joke with [staff], because [the centre] was originally [meant] for difficult to serve people, and now it's for like, the yuppies – that is, the families with young children. The neighbourhood is *totally* different than what they had envisioned when they first started that project...we're serving that population that now lives there, but that's not what the original intent of that building had been.

By tailoring services towards those with greater financial and social power rather than adapting to serve those vulnerable neighbourhood residents who might be suffering increased marginalization due to gentrification-induced displacement (or displacement pressure), this new CHC branch can be perceived as an additional axis of oppression. Jennifer's narrative highlights a problematic perspective echoed by several other frontline workers in this study: That urban CHCs are complicit in the displacement and exclusion of vulnerable populations from the gentrifying socio-spatial landscape.

Within his centre, for instance, Steve said he been a part of conversations and meetings where staff members have acknowledged the changing neighbourhood demographics. Instead of discussing and implementing strategies to address the growing and diversifying needs of vulnerable clients amidst ongoing processes of gentrification, however, he said these talks have largely been focused, instead, on how the CHC can best cater to the needs of its new, incoming clientele:

I remember there was a presentation done by, I think, the medical department, where they actually talked about the shift in demographics and how there are higher volumes of higher income people in our area...[and] how we may have to look at shifting some of our programs to *not* cater to what we were doing before...say, outreach to rooming houses and that kind of thing. [...] Rather than saying, like, this is a problem because our clients are going to be marginalized from our service, it was more like "oh – we may have to switch to meet the needs of these new, up and coming families coming in.

Jennifer concurred that the changing demographics in the surrounding neighbourhood have prompted related talks during strategic planning meetings within her own department. She said that she and many of her colleagues believe it is important to ensure that those clients who are

most vulnerable can continue to access services. However, she added, “the majority of [staff] voices say that we need to be responsive to the needs of the *current* community”.

I think we need to be looking at where we need to be serving people who are finding it difficult to access services. But I’m officially saying that there’s a divide in the centre. I think that more and more, the vulnerable populations are going to be drying up in this area, and I think our health centre has no choice but to make sure that we change our programs.

In regards to the rapid gentrification occurring in the neighbourhood around her own CHC, Erica said that her executive director, specifically, has failed to acknowledge the oppressive impact that gentrification is having on many of their centre’s vulnerable clients. In fact, Erica believes that her executive director perceives ongoing neighbourhood transformation mainly in a positive light:

I think a lot of agencies don’t really get it, and see [gentrification] as a good thing – they really want to *beautify* the neighbourhood. Like, I think my ED and my boss, they have a lot of concerns about the amount of graffiti in the area, and I’m like “Jesus fucking Christ, who cares?” Like, let’s focus on the systemic-based issues that may lead to that, and not worry so much about reducing graffiti, but have the focus be on “let’s reduce the oppression of youth”, or something similar. But the ED’s spin or the management’s spin is often around “how can we make this place look better” or “how can we look good” or “how can we appease the most vocal people with the most power”? So I don’t know how much they really get how systemic stuff is the reason for what they perceive as like, behavioural or micro-based stuff, and sometimes I wish they *got it* instead of me having to help them get it.

By seemingly failing to confront how processes of gentrification and “beautification” may be impacting those in society with less capital or political power, this example demonstrates an alignment of a CHC’s strategic priorities with neoliberal discourses and capitalism, and a problematic disconnect with vulnerable clients’ needs. Though a combination of lived experiences, socio-economic statuses and levels of interaction with vulnerable populations can all contribute to staff members’ positionalities in terms of what service provision should look like, the neoliberal perspective of CHC management can ultimately mean the difference between the creation of empowering or oppressive spaces of care.

### **The marginalization of frontline workers and increasing barriers to care**

Already positioned at the top of hierarchical structures, CHC management can be inherently disconnected from the needs of neighbourhood residents. In their study of Philadelphia-based non-profit directors' views of neighbourhood problems and social service needs, for instance, Kissane and Gingerich (2004) found that individuals in these powerful positions often “held more similar views with each other than they did with residents within their own communities” (p. 311); leading to a misalignment between top-down planning and actual client needs. While non-profit directors in Kissane and Gingerich's (2004) study viewed unemployment and educational issues as the major barriers facing their communities, for example, residents communicated that they faced more pressing, everyday challenges related to crime and violence/safety. With the inherent failure of CHC management to understand the needs of their neighbourhood's most vulnerable clients, it becomes increasingly unlikely for health equity to be achieved amidst neighbourhood gentrification, as clients' needs shift and grow.

The impact of the disconnect between the priorities of CHC management and the needs of vulnerable clients in an urban Ottawa context can be illustrated through one example from Erica, which details an instance where her executive director (ED) attended a local consultation on the police carding of citizens, by herself. Though carding<sup>8</sup> is an issue that Erica routinely deals with in her direct interactions with clients, she said that her ED did not communicate this activity to Erica ahead of time, or solicit the help of any of the centre's frontline workers in preparation for the consultation:

It's kind of problematic because I didn't even know that we were going to that [consultation] as an agency – and I'm a worker that probably could have provided feedback more than anyone else about the impact of carding, [including] feedback from the community. But I was never reached out to for any input. Then the ED is going in without any of that frontline knowledge, and is getting convinced by police partners that there are just a few bad apples [in the police force], and that the police are great. So that's sort of how she came out of that meeting, and then that's what was directed down to me. That's one of the most frustrating pieces.

As police presence continues to grow in the gentrifying neighbourhood around her CHC, Erica said that the practice of carding has become a significant concern for some of her clients. At the same time, she said she has been finding it increasingly difficult to obtain support from upper

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<sup>8</sup> Police carding involves the “random stopping” – often racially motivated – questioning and documenting of individuals when no particular offence has been committed.

management to provide education or resources to clients to help them cope with the issue of carding.

This disconnect between the needs of clients (as understood by frontline workers), the strategic priorities of CHCs (as determined by upper management) and the ability of frontline workers to deliver empowering services is extremely problematic, given the intersecting oppressions being produced for vulnerable populations through gentrification. As the narratives below demonstrate, vulnerable clients are at risk of health inequity not only as a direct result of their own displacement and disenfranchisement from former spaces of care, but also as an indirect outcome of the growing oppression of social service workers.

Frontline workers who spend a significant portion of their days working directly with vulnerable clients through outreach programs or drop-in services tend to perceive the impact of gentrification and neoliberalism differently than management and other staff who are more removed from direct interactions with clients. With a greater understanding of the ongoing, oppressive socio-spatial conditions impacting clients within their neighbourhoods, frontline workers often have the firmest grasp of the diverse and changing needs of vulnerable populations. However, as some of the frontline workers interviewed for this study expressed, they perceive themselves as having the *least* amount of power to establish or modify critical programs and services to mitigate shifting oppressions for clients. Themes of self-governance and marginalization emerged throughout research interviews, as participants discussed the pressures they felt to provide services under new, more homogenous models in order to retain their jobs. The overarching sentiment amongst participants was that in order to continue to provide empowering services to vulnerable clients to meet their shifting health and social needs, they must act independently of (and often, in defiance of) some of the neoliberal policies and practices of their CHCs. Together, participant narratives construct an image of an inequitable landscape of care within gentrifying neighbourhoods, where responsibility for service provision embodying an ethics of care becomes dependent upon the individual caregiver, rather than the overarching system.

According to nurse practitioner Jennifer, a number of former clients of hers have recently been displaced to neighbourhoods outside the boundaries of her CHC. Because of her centre's strict geographic limits for service delivery, she said that when clients move, she tries to help them figure out what community-based services they are entitled to – which can be a challenge

depending on which neighbourhood they are displaced to. Often, said Jennifer, ensuring that her CHCs' former clients continue to receive health services means delivering services to them "under the radar":

A community health centre offers a level of support that's not available in every neighbourhood, so [clients] sort of attach to us – but we're really limited in sneaking them in for services. Like, we sometimes just don't change their address [in their file], but really, they have secretly moved. We just had a lady in yesterday, actually, who was at the family shelter. She had a baby, and they've moved her to [social housing in another neighbourhood]. She has no idea where to go for things, and what to do, and is feeling quite isolated.

Though Jennifer brings an important ethics of care to the work she does, and does not allow imposed geographical boundaries to limit her capacity to deliver services, she is acting autonomously of her centre. The degree to which health equity and empowerment for clients is dependent on the discretion of the individual social service worker is problematic from a systemic standpoint, as there are many factors which can play into whether an individual caregiver might decide to *not* put themselves or their jobs at risk to provide vulnerable clients with critical services. While Jennifer chooses to use the limited power she has a nurse practitioner embedded in a CHC to reject neoliberal policies and prioritize the needs of vulnerable clients, Steve shares one example where the subjectivity of CHC staff can function to perpetuate oppression, instead:

I've had clients who I'd referred to [our centre's food voucher program], and then the one intake worker – who is sort of the gatekeeper around that – is very selective about who they give it to. I remember trying to figure out what the criteria was from her once, and she got super defensive and came to my manager and complained that I was questioning how she does her job. I just wanted to know so that I didn't set clients up for failure when they think they're entitled to something.

With provision of critical programs such as this being delivered in unequal and arbitrary ways, Steve has voiced one example of how some CHC staff may be perpetuating overarching neoliberal discourses that dichotomously position vulnerable clients as either "deserving" or "undeserving". As the perceived disconnect between service need and provision within his centre continues to grow, Steve said that even if he is personally able to identify individual client needs, he is often unable to provide these clients with the appropriate care or resources – unless he

engages in community-based work autonomously and without permission from CHC management:

I think some of us who work in this field just realize the best thing is to maybe work underground and push for your program; but also not rely on [your organization] to push for any wider change, because there's just so much resistance.

Erica echoed similar narratives, explaining that in order to support some of her most vulnerable clients and avoid some of the accountability “red tape”, she has on many occasions, pitched in her own money to fund certain programs or community-based initiatives. Despite her individual efforts, however, Erica expressed that overall, she feels marginalized and “hopeless” within her own professional role, and unable to advocate on behalf of clients. Additionally, Erica said she feels unable to even begin a dialogue with management about some of the detrimental impacts of gentrification that she has observed first-hand, in the context of her frontline work with clients. Working under the current neoliberal conditions within her centre means that Erica must constantly self-govern her actions, including the ways in which she supports clients:

We're really limited in the kind of advocacy that we can do. That sucks, because disruption-based advocacy can result in real change, and I can't engage in that advocacy within the role that I work. We can't go and do protests, or other things that aren't more passive. Signing a petition is usually acceptable, depending on the *wording* of the petition. Doing a protest outside a building is *not* – so I have to be sneaky when I do that (Erica, frontline social services worker).

Beyond the perceived marginalization that Erica feels as an individual frontline worker within her own CHC, the ongoing disappearance of community-based services and networks of care within the larger neighbourhood is also contributing to her feelings of voicelessness and powerlessness. This loss of collective power, she said, is also preventing her from pushing back against the detrimental impact of socio-spatial transformation, on behalf of clients:

There were some grassroots-based groups around here that are no longer, that did a lot of great work around pushing back...and I wish there was something already in place that was really thriving and that had a lot of momentum so I could just join instead of having to create or develop something. I feel if we had those kinds of vehicles I could work here, and then on my own time be a part of movements that are doing disruptive action – or tactics, rather – to stop gentrification. But for me right now, I feel like there's nowhere...and I feel hopeless about that, because in my work here, I have to be so careful about how I talk to

politicians, how I talk to the BIA, how I talk to condo owners. I have to be so *tactful*, and careful, and do it in a way that's not antagonistic, or really *advocating*.

Working within a centre where she feels a lack of autonomy to confront oppressive, neoliberal practices or alter services to suit the shifting needs of the neighbourhood's most vulnerable populations, Erica's own marginalization as a social service worker can potentially translate into inequitable health outcomes for clients. Erica's feelings of oppression in this context are not without precedent: With police brutality against youth clients having recently become a growing concern in the surrounding neighbourhood, for instance, she said she previously expressed her desire to CHC management to create a "tracking sheet" to disseminate to other frontline workers in downtown Ottawa to use to proactively track instances of police brutality, as an advocacy tool. She said this idea was quickly rejected, however, by her CHC's upper management:

There's no way that I can, as a worker here at [my CHC], be the hub for the collection of that data. It's too contentious. And it's not even contentious.... it's fucking tracking *abuse* – like, it's crazy, right? So that's a challenge I struggle with personally and professionally, and I feel like, you know, I'm just a cog in the wheel, because I get paid to not do anything about it, right?

While Erica does choose to act autonomously from her centre at times, she views her overall capability to adapt service delivery to achieve health equality for her vulnerable clients to be extremely limited. Like Jennifer and Steve, Erica is acutely aware of many of the diverse and shifting health inequities facing vulnerable clients, but is simultaneously dealing with a growing number of real and perceived barriers within the context of her CHC that prevent her from delivering empowering services.

Within gentrifying neighbourhoods, many interacting factors are contributing to the inability of CHCs to adapt to changing socio-spatial conditions, including funding cuts and increased accountability practices. While the narratives above demonstrate that many frontline social service workers do continue to approach their roles with an ethics of care, the increased level of oppression felt by some can translate into increased health inequity for clients. As vulnerable populations continue to be displaced from Ottawa's urban neighbourhoods due to economic polarization, the rising cost of rent, and dispossession of their socio-spatial environments, inclusive and accessible health and social services are becoming more critical than ever. As



CHCs continue to tailor their programs and services more and more towards the white, middle-class families moving into surrounding neighbourhoods, however, health equity is becoming further out of reach for those who are the most in need. Once perceived as safe spaces of care, this chapter illustrates how CHCs based in gentrifying neighbourhoods are now increasingly becoming sites of further oppression for vulnerable populations.

## **Chapter 5:**

### **Conclusion: Can care exist amongst the condos?**

Following five years of government applications, public consultations, and awareness campaigns, the Oasis Program at Sandy Hill Community Health Centre finally received approval from Health Canada in the summer of 2017 to open Ottawa's first-ever supervised injection site. Rob Boyd, one of the research participants in this study, had been spearheading these efforts in his capacity as the centre's harm reduction program's director, and demonstrates the potential that still exists for empowering health services to emerge amidst overarching neoliberal conditions and processes of gentrification. Problematically, however, the potential for health equity that this new program brings is at risk of being diluted by other injustices occurring in the wider, gentrifying neighbourhood.

As discussed in Chapter 3, the major condominium construction around Rob's CHC has brought with it a significant increase in police presence, which has prompted avoidance of the area by some vulnerable populations. At the same time, the Salvation Army shelter, currently located just a few blocks away from Sandy Hill Community Health Centre, is under significant risk of displacement after Mayor Jim Watson pledged in June 2017 to move the shelter out of its long-time facility, and into a different neighbourhood, effectively making it less accessible to many of Sandy Hill CHC's vulnerable clients (CTV Ottawa; 2017; Nease, 2017). Given the current neoliberal climate, the City of Ottawa's decision to move the shelter and Steve's account in Chapter 3 of the condominium board president living across the street from the Salvation Army (who would, on a daily basis, yell and swear at clients accessing harm reduction supplies), are undoubtedly linked.

Though the opening of a supervised injection site in Ottawa's downtown core is an important step forward in achieving health equity for drug-using populations, for instance, the displacement of the Salvation Army shelter could simultaneously mean new barriers to critical health and social services for other marginalized individuals or groups. In order to lead healthy, stable lives, vulnerable populations require accessibility and proximity to a *diverse* number of empowering resources, services and networks that will allow them to prosper within their communities and neighbourhoods. In order to achieve health and social justice for the marginalized residents of Ottawa's gentrifying neighbourhoods, then, overarching and intersecting oppressions must always be confronted in the shaping of policies, programs and services.

## **Main Findings**

Using a conceptual framework of intersectional feminism, this study was guided by a recognition that the health and social needs of urban residents are multi-faceted, and that oppression is experienced by marginalized bodies in varying ways and to varying degrees, depending on the particular social, economic, spatial and/or political landscape. By analyzing all researcher observations, participant narratives and literature through this lens, it became possible to produce a social justice-oriented perspective of how patterns of oppression are being produced and reproduced in an Ottawa-specific context – and how their interaction with processes of gentrification are producing new health inequalities for vulnerable populations.

Applying Wacquant's (2012) idea that there is no "big-N" form of neoliberalism, Chapter 1 is an introduction to how Ottawa's particular neoliberal climate systematically oppresses marginalized individuals and groups, and how gentrification projects and urban redevelopment/intensification policies have been introduced and implemented for the past 15 years in the nation's capital. Though Ottawa's ongoing socio-spatial changes can be seen as comparative, on a high-level, to the ongoing gentrification of other North American cities, the nation's capital has several distinguishing features that make the scope, timelines and policies related to urban development specific to the area. A critical understanding of Ottawa's social, economic and political landscape helps set the stage for a more complex and multi-faceted understanding of how the city's most marginalized residents are experiencing the impact of gentrification in both diverse and similar ways.

Following the contextualization of Ottawa's redevelopment landscape and policies, Chapter 2 explores how social and health inequalities are systematically being produced for vulnerable populations in Ottawa through "small-n" neoliberalism (Wacquant, 2012). A deeper understanding of gentrification as a neoliberal process or continuum helps clarify how its interaction with community-based social service delivery has the capacity to produce increased marginalization for the vulnerable populations who access care within rapidly transforming urban spaces. In this chapter, we see examples of how the downloading of responsibility for social services from federal and provincial governments has effectively restructured municipal bodies to be architecturally incapable of fulfilling the needs of society's most vulnerable (Walks, 2009). Though municipal and provincial funding for CHCs continues to remain generally intact, the

frontline workers interviewed in this chapter demonstrate how ongoing cuts to resources to smaller, more grassroots services and drop-in centres within Ottawa's downtown area have a significant impact on the ability of larger CHCs to deliver services, themselves. While CHCs may not be experiencing direct funding cuts, this chapter explores the link between the shifting needs of CHC clients, the ongoing privatization of public space, and the disappearance of social services within downtown neighbourhoods. Within this increasingly neoliberal service delivery environment, the burden of responsibility for health and social programs shifts further onto CHCs, who do not have the resource capacity to fill the gaps left behind by diminishing networks of care. Continuing funding cuts and government restructuring do not only limit the opportunity for health or social equity for vulnerable populations, but simultaneously widen the disparities between the privileged and the marginalized within downtown Ottawa neighbourhoods. Beyond its demonstration of governmental cuts to resources, the de-democratization of health and welfare services, and the growing zones of exclusion within urban public spaces, this chapter also analyzes how neoliberal discourses have manifested through CHCs, themselves. Here, programs and services are increasingly being delivered based on the criteria of whether or not they are economically beneficial, versus whether or not they ensure an ethics of care.

While Chapter 2 demonstrates the impact of overarching neoliberal discourses and policies on the capacity of CHCs to *deliver* services to Ottawa's most vulnerable populations, Chapter 3 analyzes how gentrification is limiting *accessibility* to services for CHC clients through displacement, economic polarization of the population, community disintegration, and the privatization of public spaces. In addition to the spectrum of oppression and health barriers already faced by vulnerable populations, concentrated, ongoing processes of gentrification occurring in downtown Ottawa neighbourhoods are now enacting new barriers for those who rely on community-based services. This chapter includes observations and examples from social service workers to illustrate the critical clash occurring between the privileged gentrifiers moving into downtown neighbourhoods, and incumbent (lower-income and/or marginalized) neighbourhood residents, whose physical movement, social autonomy and ultimate health outcomes are becoming increasingly impacted by the inequitable transformation of space. As gentrification continues to become amplified in the areas surrounding downtown Ottawa CHCs, frontline workers are noticing demographical shifts within and outside their centres, and hearing

stories of exclusion, displacement and *replacement* of vulnerable bodies with more affluent, homogenous populations.

With gentrification intensifying, and residential and commercial redevelopment functioning to permanently transform Ottawa's urban landscape, it is becoming critical for CHCs and other community-based services to re-evaluate certain programs, policies, and community outreach/engagement strategies to ensure that they are meeting the growing and shifting needs of their most vulnerable clients. However, as Chapter 4 argues, new processes of oppression are now being produced for vulnerable populations within the walls of CHCs themselves, as gentrification and neoliberal discourses interact to transform social service delivery.

While CHCs were initially established across Ontario to help mitigate the growing, oppressive health impacts that overarching neoliberal government discourses and policies pose, those who currently work on the frontlines of social service delivery identify a disconnect between the socio-spatial barriers being erected in neighbourhoods surrounding downtown CHCs, and the willingness or capacity of centres to try and mitigate the oncoming marginalization of vulnerable clients. In fact, say some research participants, not only are CHCs lacking the resources to adapt to shifting community needs, but new, oppressive processes and practices associated with a disappearing ethics of care are now emerging within centres, as programs and services become more exclusive and geared towards the new, homogenous populations moving into gentrifying neighbourhoods. As neoliberalism and gentrification interact outside CHC walls and further marginalize vulnerable populations through processes of oppression such as residential displacement, the commercialization of public space and increased policing, some CHCs are simultaneously reproducing that marginalization through the growing regulation (and punishment) of marginalized clients, the re-structuring of programs to serve the privileged, and the increased governance of social service workers. With limited resources, increasing accountability measures and loss of community networks, CHCs in Ottawa are becoming competitive and independent in nature, as they align more closely with neoliberal discourses in order to retain their place within the transforming urban landscape.

Within gentrifying neighbourhoods in Ottawa, increased oppression is currently being produced for vulnerable populations through a number of interrelated social, economic, political, and spatial factors. By extension, ensuring health equity for the city's most marginalized populations in the midst of ongoing processes of gentrification must similarly involve integrative,

intersectional policies and resources. Through the critical analysis of social service workers' observations and perspectives in regards to how the transformation of the urban landscape is impacting access to care and creating new health and social service needs, CHCs can better identify what differentials in care exist as a result of neighbourhood gentrification, and respond with more equitable solutions for those who have been (or are at risk of being) marginalized. While the transformation of the urban environment does not appear to be slowing down anytime soon in Ottawa, a more holistic understanding of how different axes of oppressions are produced – and how they interact – within gentrifying neighbourhoods can potentially lead to the re-emergence of distributive paradigms, social justice and an ethics of care amidst the condos.

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## *Appendix A (1)*

### **LETTER OF INVITATION TO PARTICIPATE IN RESEARCH (PROGRAM DIRECTOR/ADMINISTRATOR)**

Date: \_\_\_\_\_

I, Marguerite-Jeanne Deschamps (M.A. Candidate, Social Justice and Equity Studies, Brock University) am writing to request your help in facilitating the recruitment of staff from your community health centre to participate in a research project entitled *Care Amidst the Condos: Understanding Service Delivery in Gentrified Ottawa Neighbourhoods*. The purpose of this research project is to understand (from the perspective of frontline staff at community health centres in Ottawa, ON) how recent and/or ongoing neighbourhood changes (both geographical and demographical) may be having an impact on service delivery to clients.

For this study, I will be looking to conduct in-person interviews with 2-4 staff members who work directly with vulnerable clients to deliver health and social services; and have done so for at least 4-5 years at your current site. Your assistance with recruitment should not pose a significant time commitment, but would be greatly appreciated.

To ensure minimal disruption to your organization, and to protect the privacy of service workers who may not want to participate in the study, your help is needed to distribute the attached Letter of Invitation to staff members at your centre who fit the above criteria. The Letter of Invitation to potential participants asks those staff members interested in participating in the study to contact the principal investigator and myself directly.

Should staff choose to participate, they will be asked to talk about their experiences during an in-person interview during the Summer/Fall of 2015. The expected time commitment from each participant will be roughly 90 minutes (with the potential for a short follow-up interview to be conducted in Fall 2015). The name of your community health centre will not be included in the final reporting of results, nor will the names of participants from your centre (unless they consent to being identified).

This policy-oriented research has the potential to benefit your community health centre (and others) by helping to identify differentials in access and resources, and ultimately, aid in improving service provision to clients. Once this study is complete, your community health centre will be provided with a digital copy of the report (a physical copy of the report will gladly be provided as well, upon request).

This is a multi-site project, meaning that staff from two other community health centres in Ottawa will also be invited to participate in this research.

If you have any questions about your rights as a research participant, please contact the Brock University Research Ethics Officer (905-688-5550 Ext. 3035, [reb@brocku.ca](mailto:reb@brocku.ca)).

If you have any other questions, please feel free to contact myself ([md14jt@brocku.ca](mailto:md14jt@brocku.ca), 905-359-7072) or Dr. Ebru Ustundag ([eustundag@brocku.ca](mailto:eustundag@brocku.ca), 905-688-5550 Ext. 4417).

Thank you,

**Principal Student Investigator**

MJ Deschamps  
M.A. Candidate  
Social Justice and Equity Studies  
Brock University  
905-359-7072  
[md14jt@brocku.ca](mailto:md14jt@brocku.ca)

**Principal Investigator**

Ebru Ustundag, Ph.D.  
Department of Geography  
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905-688-5550 Ext. 4417  
[eustundag@brocku.ca](mailto:eustundag@brocku.ca)

**This study has been reviewed and has received ethics clearance through Brock University's Research Ethics Board (file # 14-246-USTUNDAG)**

## *Appendix A (2)*

### **LETTER OF INVITATION TO PARTICIPATE IN RESEARCH (POTENTIAL PARTICIPANTS)**

Date: \_\_\_\_\_

I, Marguerite-Jeanne Deschamps (M.A. Candidate, Social Justice and Equity Studies, Brock University) am writing to invite you to take part in a research project entitled *Care Amidst the Condos: Understanding Service Delivery in Gentrified Ottawa Neighbourhoods*. The purpose of this research project is to understand (from the perspective of frontline staff at community health centres in Ottawa, ON) how recent and/or ongoing neighbourhood changes (both geographical and demographical) may be having an impact on service delivery to clients.

For this study, I am looking to conduct in-person interviews with staff at community health centres in Ottawa, who work directly with vulnerable clients to deliver health and social services; and who have done so for at least 4-5 years at their current site.

Should you choose to participate in the study, you will be asked to talk about your experiences during an in-person interview during the Summer/Fall of 2015. The expected time commitment will be roughly 90 minutes (with the potential for a short follow-up interview to be conducted in Fall 2015).

This policy-oriented research has the potential to benefit your community health centre (and others) by helping to identify differentials in access and resources, and ultimately, aid in improving service provision to clients. Once this study is complete, you will be provided with a copy of the final report, should you request it.

This is a multi-site project, meaning that staff from two other community health centres in Ottawa will also be invited to participate in this research.

If you have any questions about your rights as a research participant, please contact the Brock University Research Ethics Officer (905-688-5550 Ext. 3035, [reb@brocku.ca](mailto:reb@brocku.ca)).

If you are interested in participating and/or have any questions about the study, please contact myself ([md14jt@brocku.ca](mailto:md14jt@brocku.ca), 905-359-7072) or Dr. Ebru Ustundag ([eustundag@brocku.ca](mailto:eustundag@brocku.ca), 905-688-5550 Ext. 4417) directly.

Upon contacting the study's investigators, you will be provided with a digital copy of the Informed Consent Letter, which provides in-depth details about the research process and data collection.

Thank you,

**Principal Student Investigator**  
MJ Deschamps

M.A. Candidate  
Social Justice and Equity Studies  
Brock University  
905-359-7072  
[md14jt@brocku.ca](mailto:md14jt@brocku.ca)

**Principal Investigator**  
Ebru Ustundag, Ph.D.  
Department of Geography  
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905-688-5550 Ext. 4417  
[eustundag@brocku.ca](mailto:eustundag@brocku.ca)

**This study has been reviewed and has received ethics clearance through Brock University's Research Ethics Board (file # 14-246-USTUNDAG)**

## *Appendix B:*

### **INFORMED CONSENT FORM**

Date: \_\_\_\_\_

**Title of Project:** Care Amidst the Condos: Understanding Service Delivery in Gentrified Ottawa Neighbourhoods

**Principal Investigator:** Dr. Ebru Ustundag, Department of Geography, Brock University

**Principal Student Investigator:** Marguerite-Jeanne (MJ) Deschamps, M.A. Candidate, Social Justice and Equity Studies, Brock University

- You are invited to participate in a study that involves research. The purpose of this study is to understand, from the perspective of frontline staff at community centres in Ottawa, ON, how recent and/or ongoing neighbourhood changes may be having an impact on service delivery to clients.
- As a participant, you will be asked to partake in an in-person interview with the principal student investigator during the Summer/Fall of 2015 (or as your schedule permits). Participation will take approximately 90 minutes of your time. Interviews will be conducted in a private room in the community health centre, or in another private location of your choosing. With your agreement, you may also be contacted within 4-8 weeks of the original interview to ask you another set of similar questions. You may decide at that time whether or not you wish to participate in any subsequent part of the study. A follow-up meeting will only be requested if, once all data is collectively analyzed for themes, certain themes or narratives emerge that warrant further exploration
- You are under no obligation to participate in this study. This study focuses on social service delivery, and **not** the organization you work for, so there should be no pressure felt to participate from your employer.
- All interviews will be audiotaped with an Olympus WS-311M Digital Voice Recorder, and an interview journal noting observations will also be kept. All personal data will be kept strictly confidential, and responses to interview questions will be coded so that your name will not be associated with your answers, unless you choose to be identified (see bullet point below). A master list with participant names and contact information will be kept in a password-protected computer folder, and each participant will be assigned a random numeric identifier. Only the principal investigator and principal student investigator will have access to the data during the course of the study. If you choose to have your data reported anonymously in the study, you will be referred to as Participant #\_\_\_\_. Following the publication of the report, your data will be retained in a password-protected computer folder for five years, in the event that the data collected fits into the context of a subsequent research study. Following the report's publication, only the student investigator will have access to the study's data. After five years, all data will be permanently erased/deleted by the student investigator.

- With your consent, data will be retained for five years following the study's publication, in the event that the student investigator pursues a PhD, and the data collected lends itself to further academic research. Your coded personal identifiers will be retained in a password-protected computer folder, so that the student investigator may get in touch with you if needed.
- If you wish to have your name associated with your data in the final report, please indicate that below. Otherwise, all information you provide is considered confidential, and your name will not be included in the study. With your permission, however, anonymous quotations may be used.
- Though you may choose to have your name associated with your data in the final report, the name of your employer (re: the community health centre) will **not** be included in the final reporting of results.
- If you do **not** wish to have your name associated with your data in the final report, anonymous reporting of the aforementioned data *may* still run into limitations in terms of confidentiality. Given the small number of potential participants from each site, your director/manager's involvement in recruitment, and the fact that most interviews will be conducted on site (you may suggest an alternative, more confidential location however, which I will be happy to accommodate), there is the possibility that participation may become known to others (though *anonymity* of data will remain).
- Shortly after the interview has been completed, I will send you a copy of the transcript to give you an opportunity to confirm the accuracy of our conversation and to add or clarify any points that you wish. The transcript will be returned to you via email, and all comments/clarifications should be sent back to the investigators by replying to the email sent. If you would like to receive and/or return the transcript via hard copy, please notify the student investigator (either by phone, email, or during the interview), and we would be happy to accommodate that request. The transcript review process should take approximately 1-3 hours of your time, depending on the number of clarifications you choose to make. It would be appreciated if reviewed transcripts were returned 3-6 weeks after being received. If the investigators do not receive a response within 8 weeks of the transcript being delivered, it will be assumed that no clarifications are required.
- Your participation in this study is voluntary, and you may withdraw from the study at any time and for any reason without penalty. Should you choose to withdraw from the study, any data or personal identifiers collected will be immediately and permanently erased from any computer files/digital recording devices.
- If you wish, you may also decline to answer any question(s) posed during the formal interview(s). If desired, the principal investigator can also provide a list of questions to participants prior to the formal interview.
- There will be no monetary payment or other compensation for your participation.

- Results of this study may be published in professional journals and presented at conferences. Potential venues for sharing research include the Congress of the Humanities and Social Sciences and Brock University research days.
- Once this study is complete, your community health centre will receive a copy of the final report via your program director/manager. Upon request, you will also be provided with a copy of the final report.
- This is a multi-site project, meaning that staff from two other community health centres in Ottawa will also be invited to participate in this research.
- This policy-oriented research has the potential to benefit your community health centre (and others) by helping to identify differentials in access and resources, and ultimately, aid in improving service provision to clients.
- There are **no** known or anticipated risks (i.e. social, physical, psychological) associated with participation in this study
- If you have any questions about this study or require further information, please contact MJ Deschamps ([md14jt@brocku.ca](mailto:md14jt@brocku.ca), 905-359-7072) or Dr. Ebru Ustundag ([eustundag@brocku.ca](mailto:eustundag@brocku.ca), 905-688-5550 Ext. 4417).
- This study has been reviewed and received ethics clearance through the Research Ethics Board at Brock University (file # 14-246-USTUNDAG). If you have any questions about your rights as a research participant, please contact the Brock University Research Ethics Officer (905-688-5550 Ext. 3035, [reb@brocku.ca](mailto:reb@brocku.ca)).

Thank you for your assistance in this project. Please keep a copy of this form for your records.

## CONSENT FORM

I agree to participate in this study described above. I have made this decision based on the information I have read in the Information-Consent Letter. I have had the opportunity to receive any additional details I wanted about the study and understand that I may ask questions in the future. I understand that I may withdraw this consent at any time.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Do you consent to the retention of your personally identifying information by the student investigator for five years following the publication of this study, for the purpose of possible secondary use? (If you do not consent to data retention for possible secondary purposes, any personal identifiers and/or data collected from you will be destroyed within a month of the report's completion). With your consent, data will be retained for five years following the study's

publication, in the event that the student investigator pursues a PhD, and the data collected lends itself to further (related) academic research.

YES \_\_\_\_ NO \_\_\_\_

If you answered 'YES' to the above question, please check one of the boxes below to respond to the following question: Do you consent to the principal and/or student investigator potentially contacting you again in the future to discuss the possibility of gathering additional data?

YES \_\_\_\_ NO \_\_\_\_

Do you consent to your real first name being published in the final report, alongside any data used from your participant interviews? If you do not consent to this, a pseudonym will be used in place of your name.

YES \_\_\_\_ NO \_\_\_\_

Would you like to receive a digital copy of this research study once it is complete?

YES \_\_\_\_ NO \_\_\_\_



## *Appendix C*

### **SAMPLE INTERVIEW GUIDE**

1. How long have you worked at this particular community health centre – and in what capacity? Can you describe how the neighbourhood has changed since you began working here? Have any of these changes impacted aspects of your interactions with clients?
2. What are some of the biggest challenges you (and other social service workers) are currently facing in regards to service delivery to clients? How are neighbourhood changes (either demographical or geographical) having an impact on service delivery? How have different aspects of service delivery been changing for you – and have there been any changes in the way services are being distributed to clients?
3. Have clients expressed to you their feelings about the role/significance/impact of the services you distribute on their own lives and livelihoods? What are some of the common – or particular – narratives you have heard? Have these narratives changed at all, in recent years?
4. From your perspective, how have neighbourhood changes – and changing downtown cores, as a whole – been impacting clients who access community health services? What are some things you have seen or heard firsthand that you can share, without identifying specific clients? Have you seen any changes in the way clients in general access certain programs/services?
5. What changes in service delivery/resources are needed to help improve service provision to clients? How are neighbourhood changes impacting this need?

## Appendix D

### PHOTOGRAPHS OF NEIGHBOURHOOD TRANSFORMATION



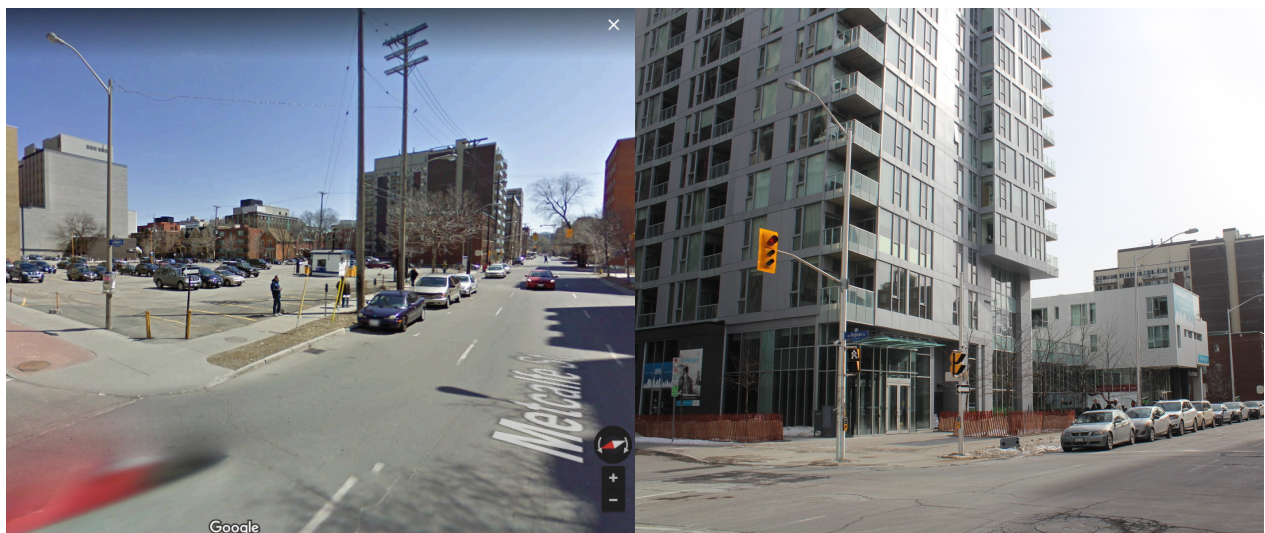
**Fig.1: *Sandy Hill/Byward Market*** – What used to be a public green space that visitors to the Ottawa Mission shelter across the street or the Youth Service Bureau down the block could traverse is now the site of a massive condominium and art gallery project. (Credit: MJ Deschamps, 2018)



**Fig. 2: *Sandy Hill/Byward Market*** – Located a few blocks down from Sandy Hill Community Health Centre, the newly-branded “Cadillac Fairview” Rideau Centre has undergone a major transformation and expansion in recent years. What used to be a run-down Sears and an empty parking lot where many panhandlers and homeless individuals would converge has been replaced by a Nordstrom, a Simons and many other high-end retailers. (Credit: MJ Deschamps, 2018)

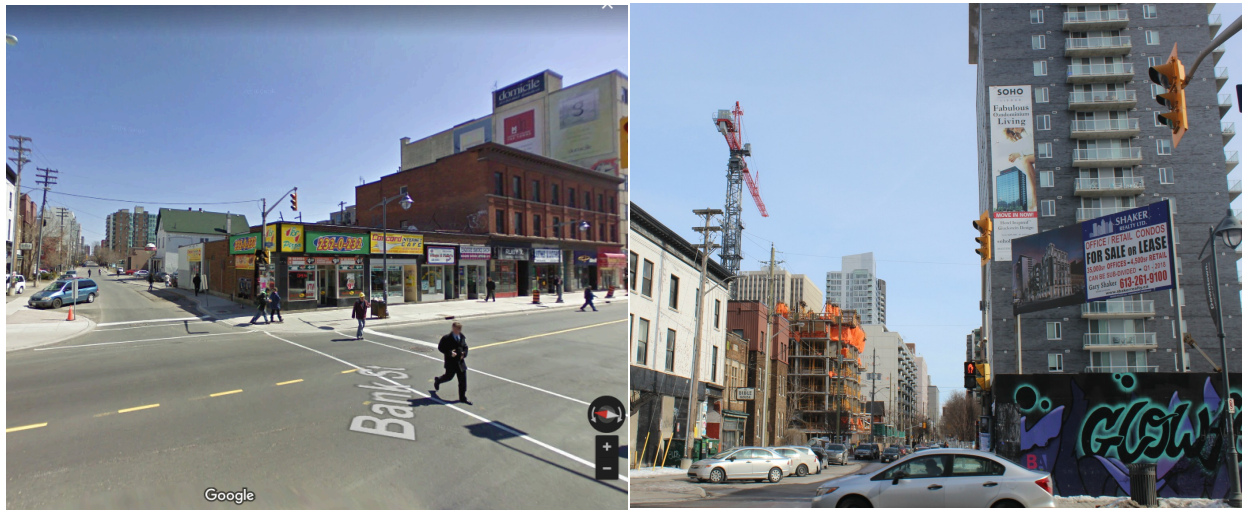


**Fig 3: Sandy Hill/Byward Market** – Around the time that a number of condominium projects and the construction of the new LRT began to overtake Rideau Street, new digital signs and large, wrap-around barriers were erected in the area, urging people to keep the “new downtown Rideau” “safe” and “clean” by reporting “issues”: A blatant example of the neoliberal discourses working to privatize public spaces for the residents of the new, surrounding condos. (Credit: MJ Deschamps, 2018)



**Fig 4: Centretown** – Figures 4-7 illustrate some of the striking changes to the urban landscape that have occurred in Ottawa’s Centretown neighbourhood between 2012 – 2018. The images on the left depict the “before”, while the images on the right depict the “after”. Left: The corner of Metcalfe Street and Nepean Street, circa 2012 (Source: Google Street View). Right: The corner of Metcalfe and Nepean Street, circa 2018 (Source: MJ Deschamps)





**Fig 5: Centretown** – Left: The corner of Bank Street and Lisgar Street, circa 2012 (Source: Google Street View). Right: The corner of Bank Street and Lisgar Street, circa 2018 (Source: MJ Deschamps).



**Fig 6: Centretown** – Left: The corner of Lyon Street and Gloucester Street, circa 2012 (Source: Google Street View). Right: The corner of Lyon Street and Gloucester Street, circa 2018 (Source: MJ Deschamps).



**Fig 7: Centretown** – Left: The corner of Bay Street and Gloucester Street, circa 2014 (*Source: Google Street View*). Right: The corner of Bay Street and Gloucester Street, circa 2018 (*Source: MJ Deschamps*).